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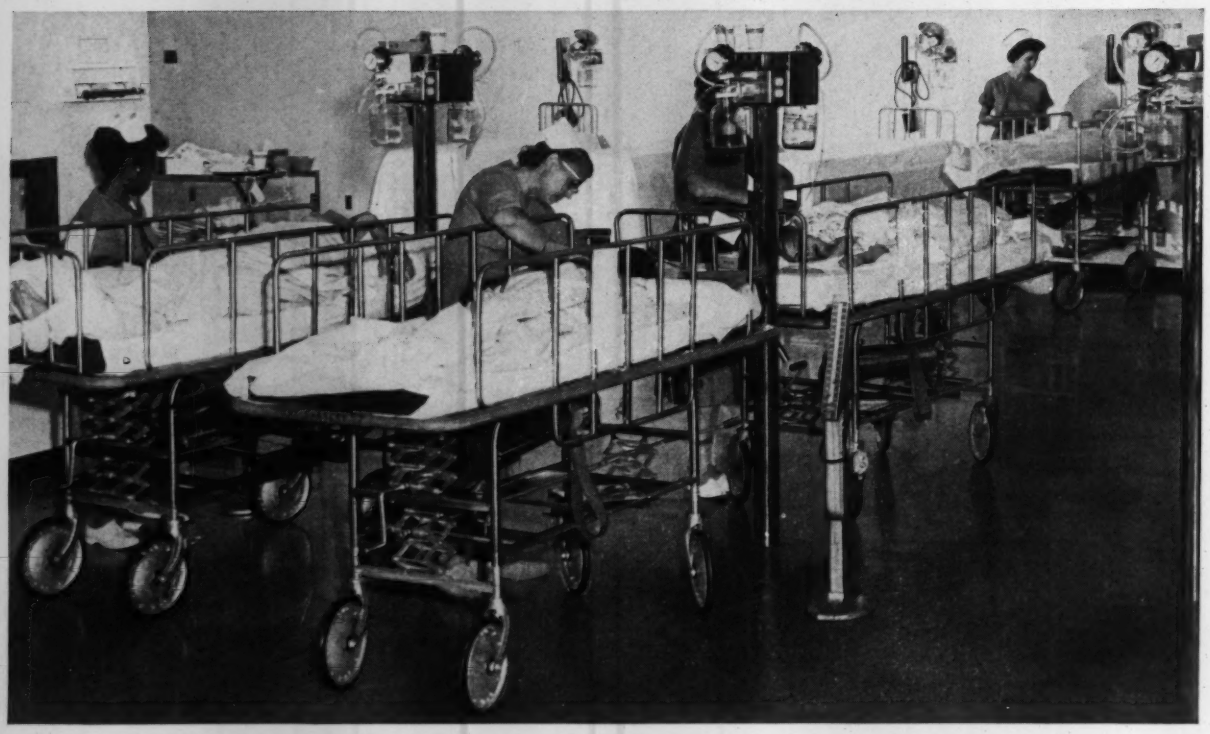
HOSPITALS

JOURNAL OF THE
AMERICAN
HOSPITAL
ASSOCIATION

FEBRUARY 16, 1961

PSALM-INSPIRED
HOSPITAL CHAPEL

(PAGE 46)



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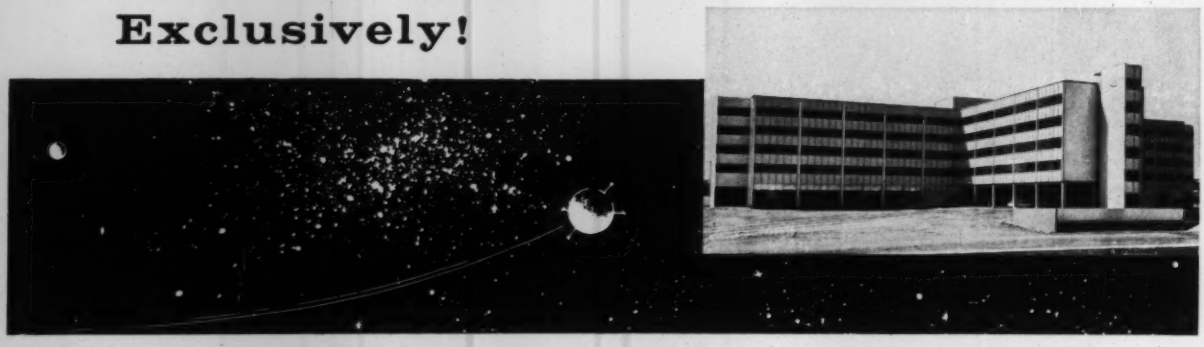

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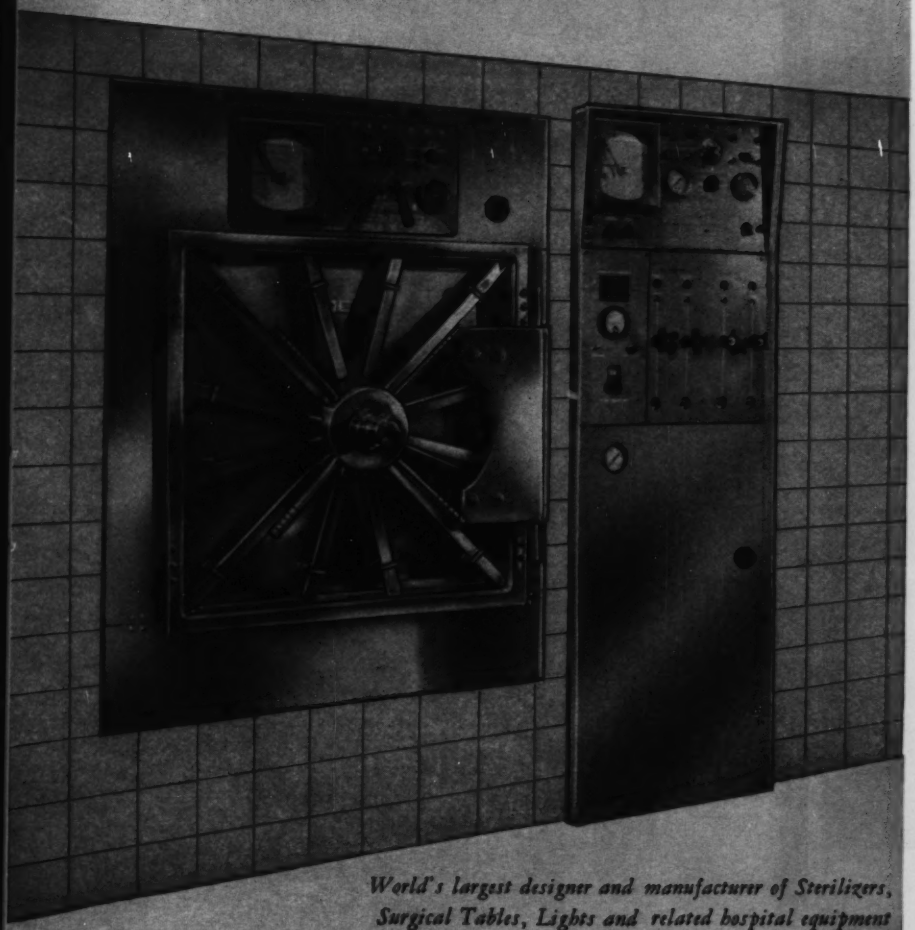

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A.S.A.® (acetylsalicylic acid, Lilly)

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HOSPITALS

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cover

No formal ceremony marked the opening of the new interdenominational chapel of the Moline Public Hospital, Moline, Ill., but it was ready for preview by clergy and visitors on Dec. 13, 1960. The chapel, a gift to the hospital, was designed by Henry Hill of San Francisco. Construction details and more pictures of the chapel appear on page 46. Cover photo by Roger Sturtevant, San Francisco. (Other photo credits on page 132).

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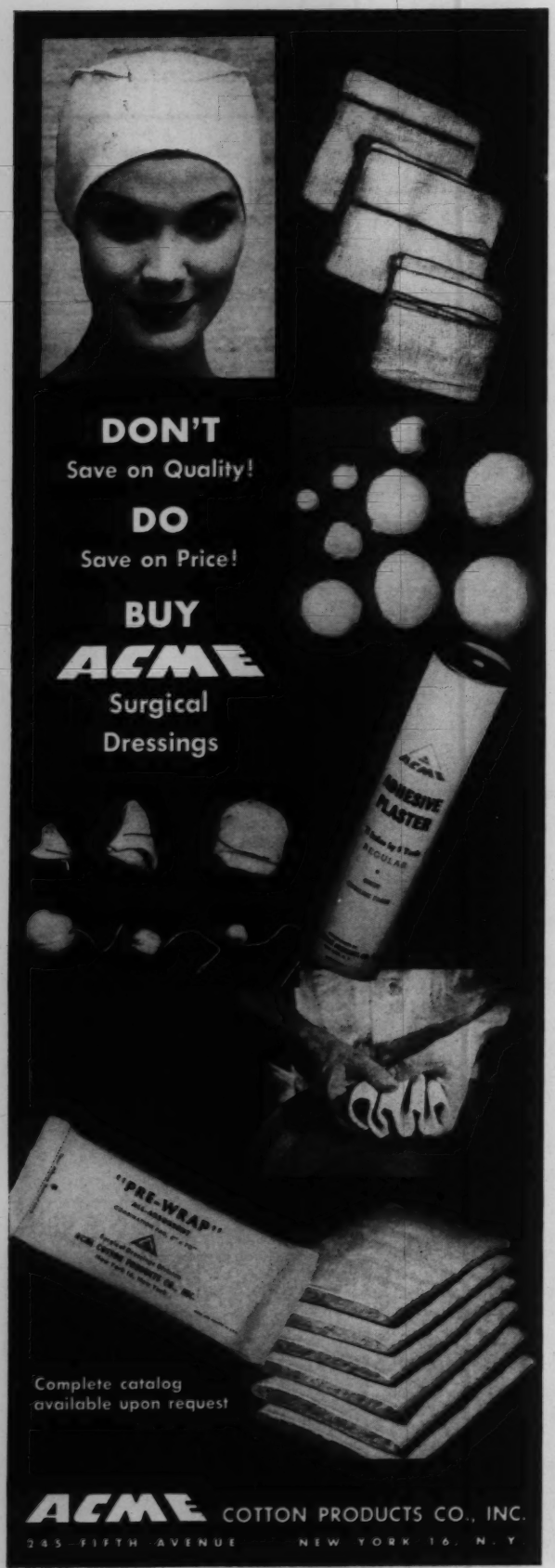

hospital association meetings

AMERICAN HOSPITAL ASSOCIATION
NATIONAL MEETINGS

1961

Sept. 25-28—**63rd Annual Meeting,** Atlantic City (Convention Hall)

MEETING AND INSTITUTE
CALENDAR

THROUGH JULY 1961

(American Hospital Association Institutes are in BOLDFACE type. Meetings of other hospital associations are in LIGHTFACE type. *Other organizations in the health field are shown in ITALICS.)*

FEBRUARY

23-25 Louisiana Hospital Association, Shreveport (Captain Shreve Hotel)
27-Mar. 1 **Management Development,** Chicago (AHA Headquarters)
27-Mar. 3 **Nursing Service Administration,** Houston, Tex. (Rice Hotel)

MARCH

3-16 *National Health Council,* National Health Forum, New York City (Waldorf-Astoria)
6-8 **Hospital Law,** Austin, Tex. (Commodore Perry Hotel)
6-10 **Hospital Purchasing,** Pittsburgh (Penn-Sheraton Hotel)
16 Wisconsin Hospital Association, Milwaukee (Schroeder Hotel)
20-22 **Personnel Administration (Basic),** Chicago (AHA Headquarters)
20-22 New England Hospital Assembly, Boston (Hotel Statler)
20-23 **Obstetrical Nursing Administration,** Los Angeles (Statler Hilton Hotel)
21-23 Kentucky Hospital Association, Lexington (Phoenix Hotel)
23-24 Georgia Hospital Association, Atlanta (Biltmore Hotel)
27-29 **Methods Improvement (Advanced),** Chicago (AHA Headquarters)

APRIL

4-7 Ohio Hospital Association, Columbus (Veterans Memorial Auditorium)
5-7 **Capital Financing of Hospitals,** Chicago (AHA Headquarters)
10-14 *National League for Nursing,* Cleveland (The Arena)
12-14 **Labor Relations,** Chicago (AHA Headquarters)
13-14 Carolinas-Virginias Hospital Conference, Roanoke (Hotel Roanoke)
16-20 *Annual Conference of Blue Shield-Blue Cross Plans,* Chicago (Edgewater Beach Hotel)
17-18 **Institute on Credits and Collections,** Detroit (Sheraton-Cadillac Hotel)
19-21 Quebec Hospital Association, Montreal (Queen Elizabeth Hotel)
19-21 **Hospital Librarianship,** Chicago (AHA Headquarters)
19-21 Southeastern Hospital Conference, Memphis (Municipal Auditorium)
23-28 *American Pharmaceutical Association,* Chicago (Hotel Sherman)
23-28 *American Society of Hospital Pharmacists,* Chicago (Hotel Sherman)
24-25 *National Association of Boards of Pharmacy,* Chicago (Hotel Sherman)
24-27 Association of Western Hospitals, San Francisco (Civic Auditorium)
24-27 **Nursing Inservice Programs,** New York City (Sheraton-Atlantic Hotel)
24-28 **Medical Record Librarians, on Principles of Medical Record Management (Advanced),** Chicago (AHA Headquarters)
24-28 *National Association for Practical Nurse Education and Service,* Detroit (Statler Hilton Hotel)
25-28 **Hospital Engineering,** Dallas, Tex. (Adolphus Hotel)
26-27 Iowa Hospital Association, Des Moines (Fort Des Moines Hotel)
26-28 Midwest Hospital Association, Kansas City (Municipal Auditorium and President Hotel)

MAY

1-3 Tri-State Hospital Assembly, Chicago (Palmer House)
4-5 *Association of University Programs in Hospital Administra-*

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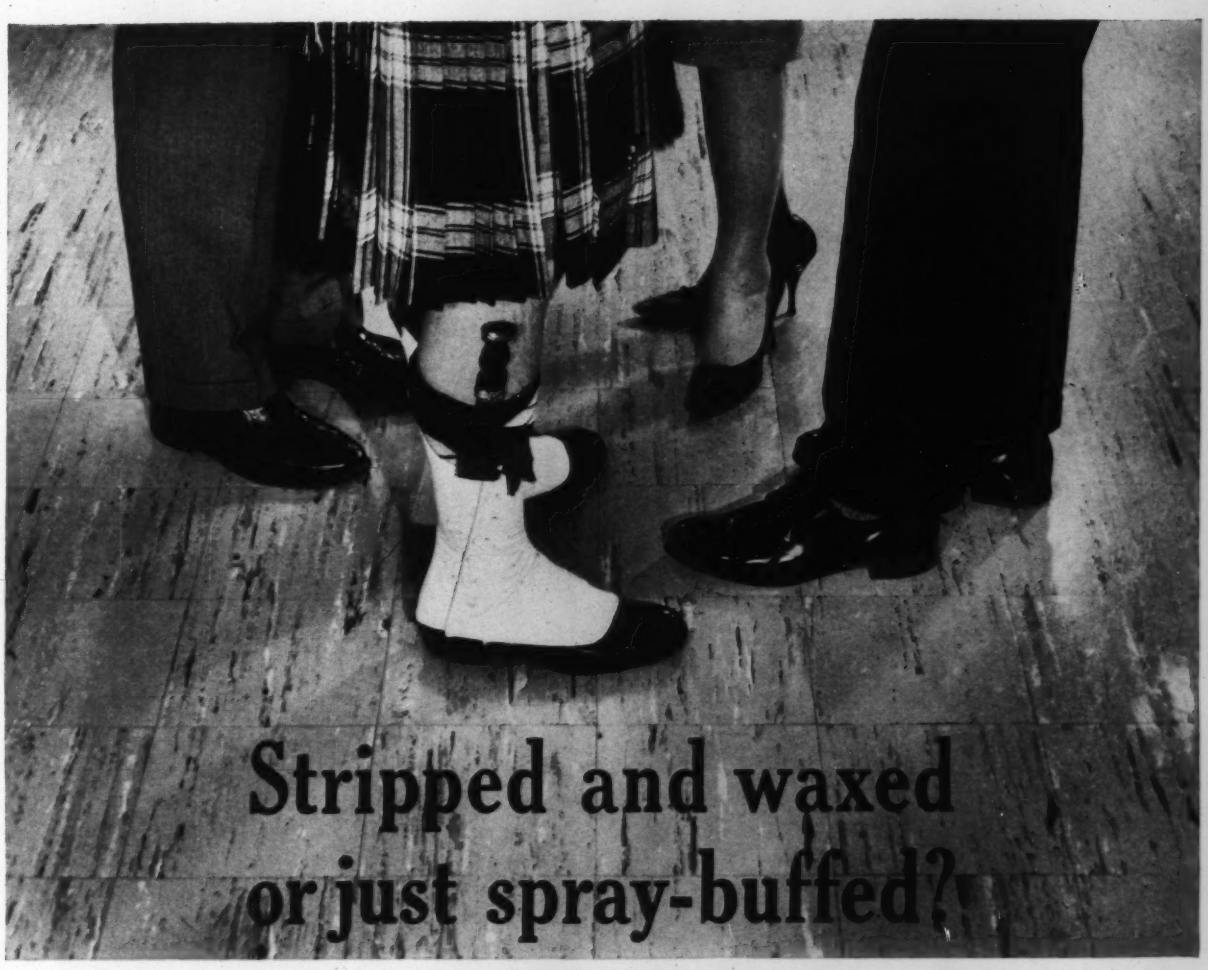

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introducing the authors

Willard C. Rappleye, M.D., president of the Josiah Macy Jr. Foundation, New York, for the past 20 years, discusses in detail the problem of the foreign medical graduate and its impact on hospitals (p. 54).

DR. RAPPLEYE

Dr. Rappleye, during his distinguished career in medical education and hospital administration, was dean of the faculty of medicine at Columbia University as well as professor of hospital administration at both the University of California, Berkeley, and the Yale University School of Medicine.

Dr. Rappleye has held such other important posts as Commissioner of Hospitals for the City of New York and chairman of the Commission on Graduate Medical Education.

A past president of the Association of American Medical Colleges, Dr. Rappleye currently serves as a trustee of the National Fund for Medical Education. He is also a trustee of Roosevelt Hospital, New York.

Dr. Rappleye's numerous organizational affiliations include fellowship in the American Medical Association, the American College of Physicians and the American College of Hospital Administrators.

He received his medical degree from Harvard University.

Roderic M. Bell reports on the drug prepackaging system that was developed for a large hospital in his article on p. 77. Mr. Bell, former assistant administrator for the Dallas (Tex.) County Hospital District, is now administrator of Presbyterian Hospital of Dallas, Tex.

Mr. Bell was associated with the Dallas County Hospital District for eight years (1952-1960) before joining the staff of Presbyterian Hospital of Dallas last July 1. Prior to receiving his master's degree in hospital administration from Washington University in 1952, Mr. Bell served his administrative residency at Baylor University Medical Center of Dallas, Tex.

Mr. Bell's organizational affiliations include fellowship in the American College of Hospital Administrators and chairmanship of the Texas Hospital Association council on hospital planning and plant operation.

He completed his undergraduate work in business administration at the University of Arkansas, Fayetteville.

Ruth E. Silvester, director of dietetics at Allegheny General Hospital, Pittsburgh, Pa., describes how equipment and an efficient layout can help merchandise quality food in an employees' cafeteria (p. 82).

MISS SILVESTER

In addition to working with the architects, food service consultants and administration on construction of the recently completed dietary facilities at Allegheny General Hospital, Miss Silvester has found time to be an active participant in national, state and local dietetic and hospital association activities.

A member of the American Dietetic Association, Miss Silvester is a past president and treasurer of both the Pennsylvania and Pittsburgh dietetic associations.

She received her B.S. degree from the University of Akron (Ohio) and completed her dietetic internship at Massachusetts General Hospital, Boston.

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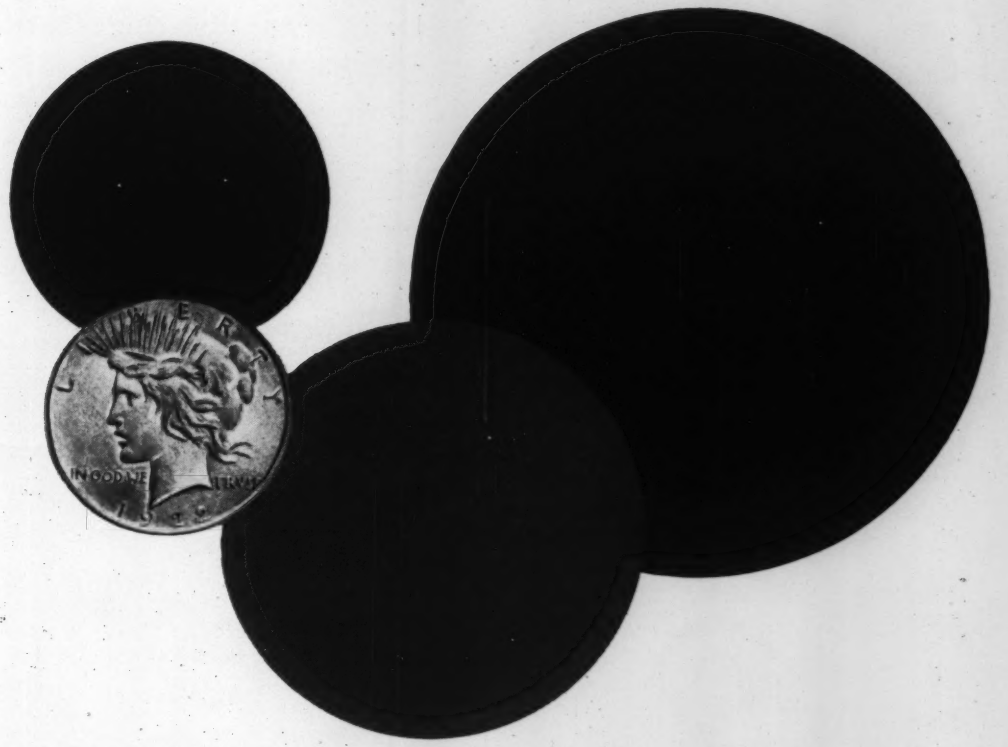

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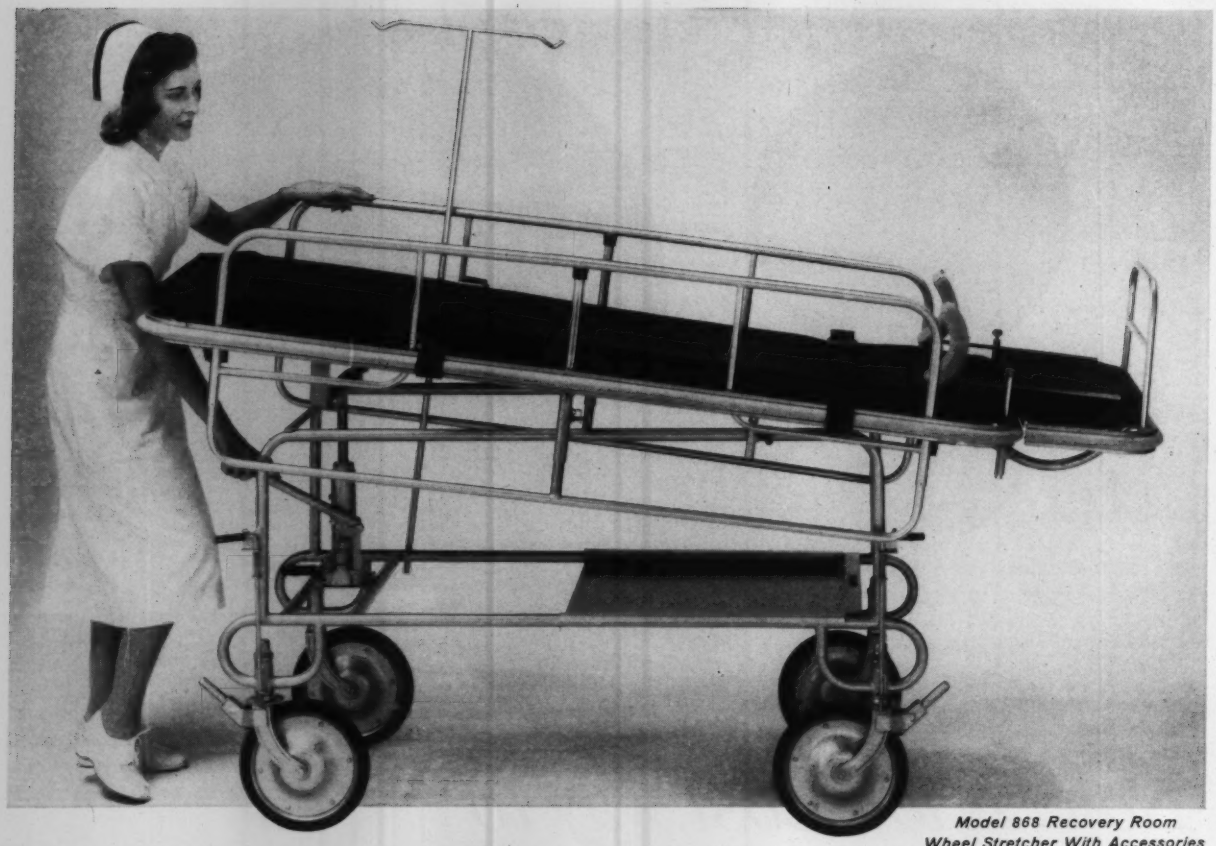

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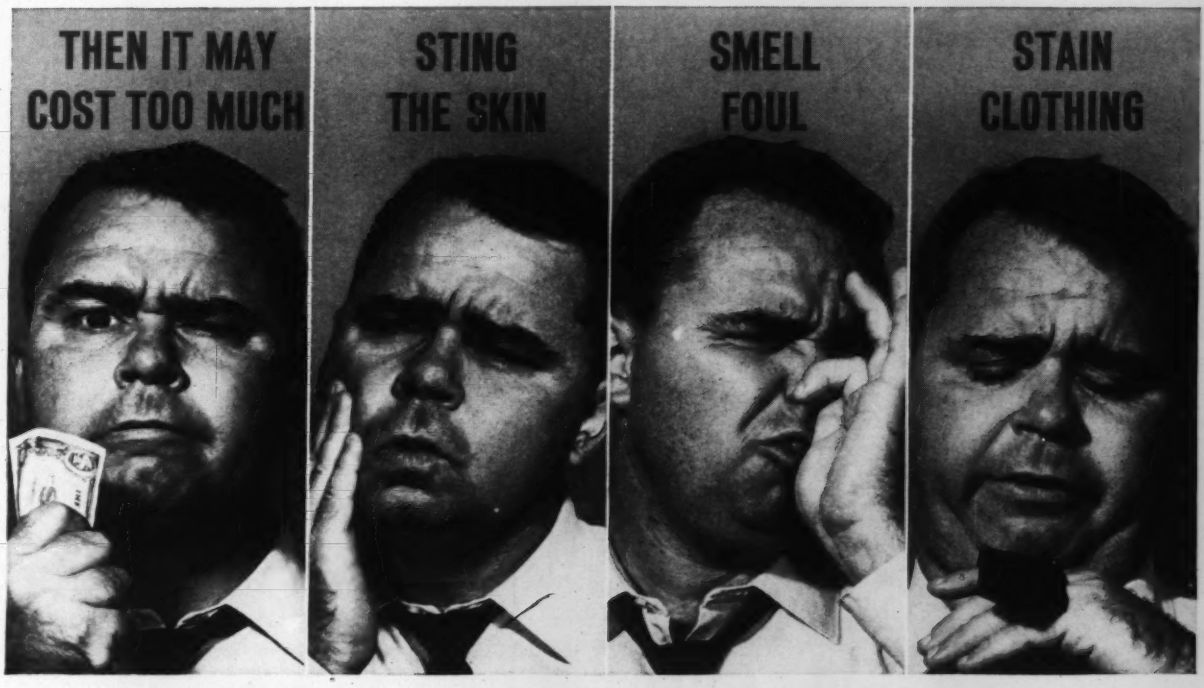

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STERILE
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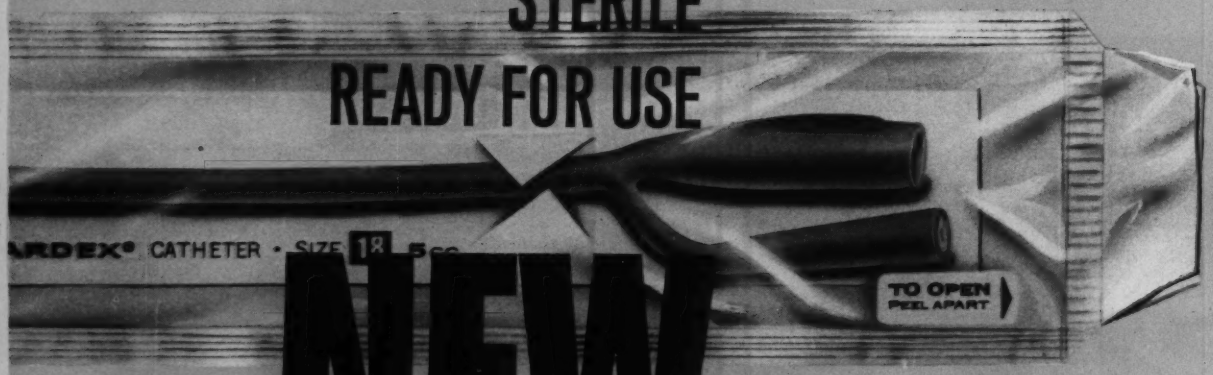

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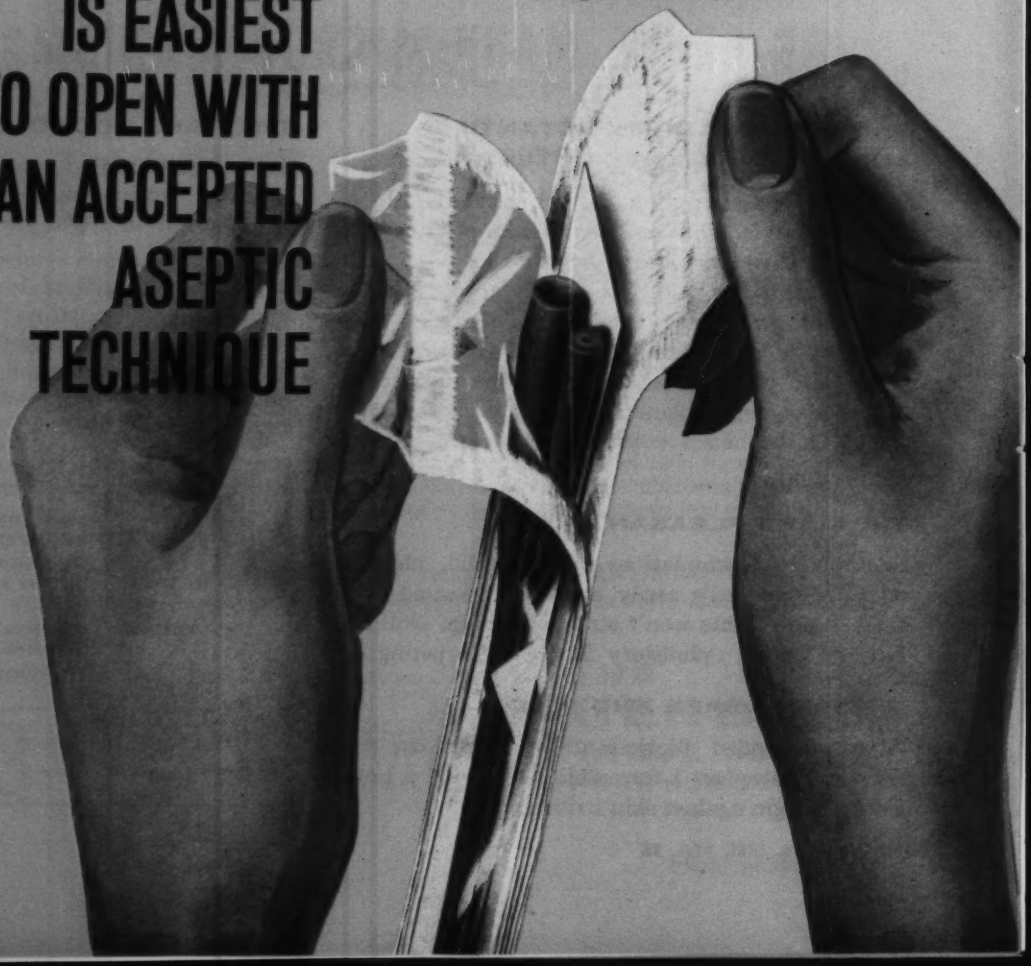
STERIL-PEEL PACKAGE IS EASIEST TO OPEN WITH AN ACCEPTED ASEPTIC TECHNIQUE

To open, simply pull tabs back and away from sterile interior



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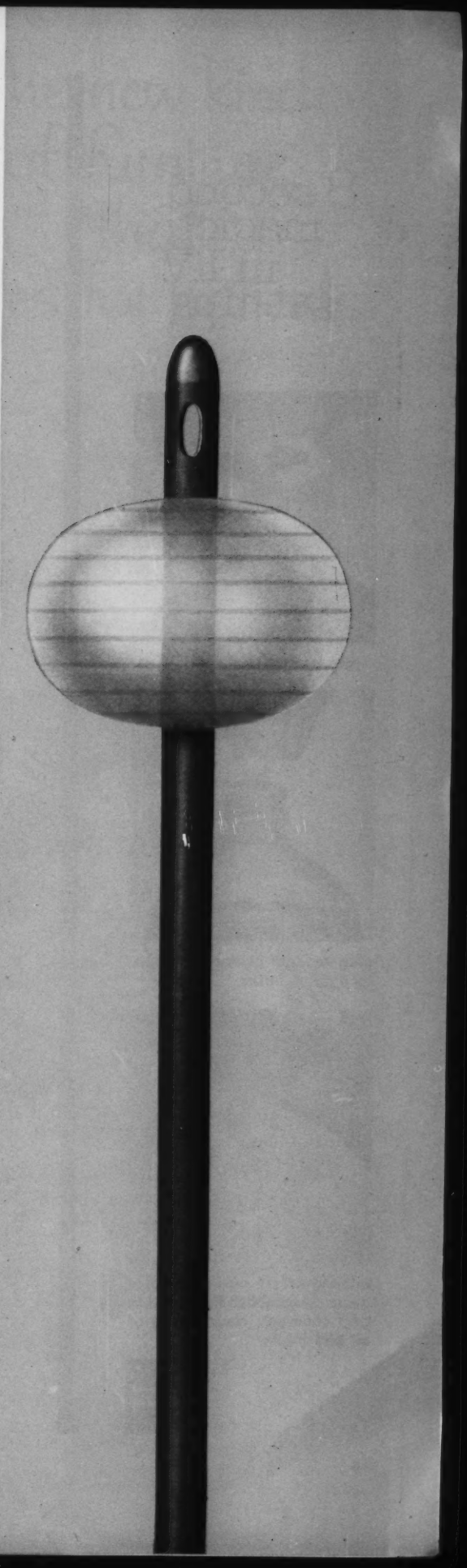

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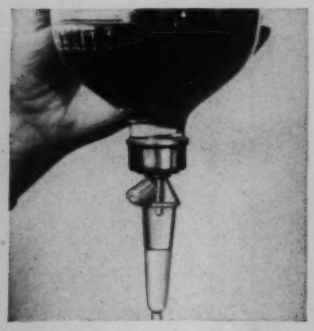
remove metal seal and disc

plug set into center of stopper by a quick thrust



quickly invert bottle to automatically establish fluid level in drip chamber; clear tubing of air and infuse

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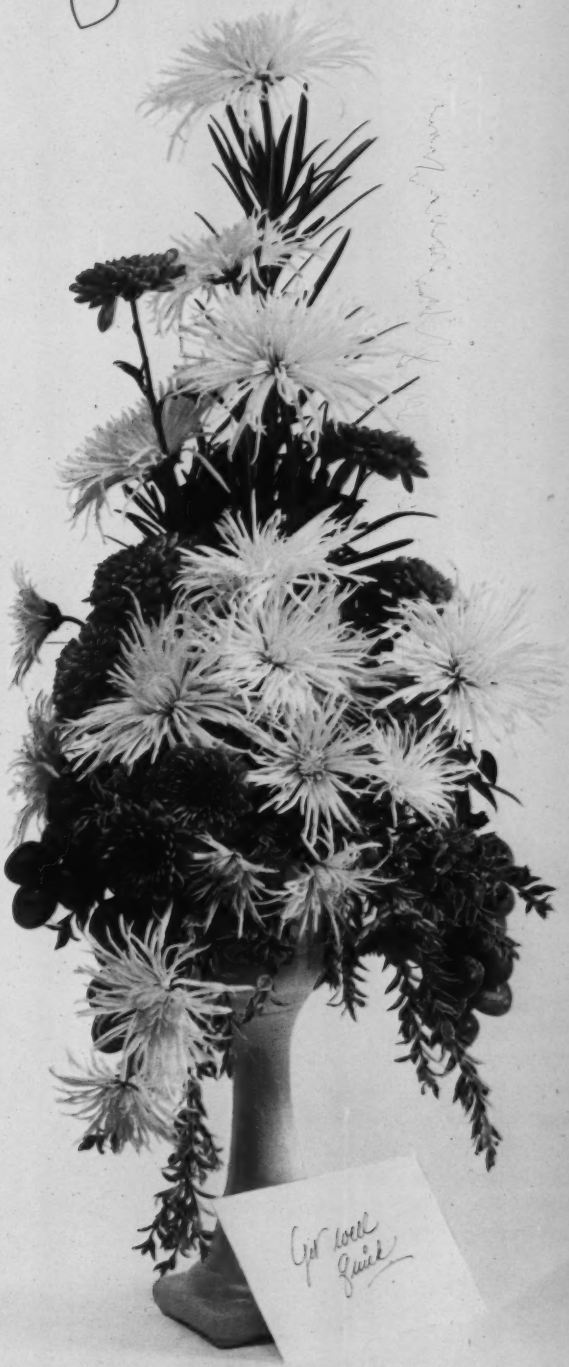

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sides. Or the Overb
with the bed.

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Bedside Susan is another case in point. Nurses love it, patients too. It has revolving shelves, sliding door, and swivel top for access and convenience unheard of in patient-room furniture.

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room furniture by AMERICAN SEATING

Rest-O-Matic Lounge Chair saves nurses' time, saves valuable space, cuts costs, looks better, lasts longer. A slight shift in weight lets patient change it from straight back to lounge position. So easy, so comfortable, so smart, you'll want one in your home, too. Try it!

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REPORT FROM WASHINGTON—In his first State-of-the-Union message, President John F. Kennedy indicated his intent to keep his campaign pledges regarding the health field. He emphasized that a health care program for the aged under social security "must be undertaken this year."

The new President's speech confirmed the final Eisenhower budget as the basic blueprint for the first year of the Kennedy administration, but he said that some changes will be proposed to Congress, relating to his key programs. The 1962 Eisenhower budget figures are generally a little higher than they were for 1961.

Appropriations for specific projects in the health field include $25 million more than in 1961 for the Hill-Burton program, and $140 million more for the National Institutes of Health medical research program. For health research facilities, the Eisenhower budget figure is $30 million, or $5 million more than in 1961. The budget also includes $73.1 million for the "Medicare" program and $5.3 billion for Veterans Administration expenditures.

● Former President Eisenhower went on record as favoring a broader program of health care for the aged before he left office. He said a federal-state program is a sound national policy, but added that under the Kerr- Mills program, many aged will still not obtain needed protection against catastrophic hospital and medical expenses.

● Luther Leonidas Terry, M.D., has been appointed Surgeon General by President Kennedy. The former Public Health Service career medical officer, told newsmen that he personally supported the social security method of financing health care for the aged. He also said that he was personally convinced that the 15 per cent ceiling on indirect costs of National Institutes of Health research projects "does not pay indirect costs," and that he is in accord with raising it. *(Details p. 113)*

VARIED HEALTH BILLS INTRODUCED IN NEW CONGRESS—There were a multitude of new bills introduced in the opening weeks of the 87th Congress, including a varied assortment in the health field. Among the latter, a few which warrant watching are:

Professional Nurse Education: H.R. 2445, introduced by Rep. Kenneth Roberts (D-Ala.), who sponsored a similar bill in the last Congress on which no action was taken. It calls for grants to aid states in strengthening professional nurse education. The American Hospital Association supported it last year and supports it this year, as in line with principles advocated by the AHA.

Practical Nurse Education: S. 278, introduced by Sen. Lister Hill (D-Ala.), which would extend the practical nurse training program now due to expire June 30, 1961. AHA also supports this bill.

Aged Health Care: S. 65, introduced by Sen. Pat McNamara (D-Mich.), providing for social security financing of health benefits for the aged, from age 65 for men and age 62 for women. For those not under social security, this bill proposes health coverage through a federal medical insurance trust fund. Although the bill is in accord with the basic Kennedy-backed principle of social security financing, it was not expected to be the Kennedy administration bill.

OHIO LAW RESTRICTS TITLES OF HOSPITAL CERTIFICATES—Ohio hospitals may use only the titles "Hospital Record of Birth" and "Hospital Birth Record" on the documents they issue to new parents relative to births.

In a statement to hospital administrators in Ohio, Donald R. Newkirk, associate director of the Ohio Hospital Association, explained and clarified a recently enacted ruling by the Ohio General Assembly on certificates.

The section of the law regarding the issuing of certificates reads: "No person shall make or issue what purports or simulates to be a certified copy, certification, or certificate of birth, death, stillbirth, marriage, annulment of marriage, or divorce or any part thereof; except those persons specifically authorized by law to do so."

The legislation was enacted as a result of the issuance by funeral directors, hospitals and other nonofficial agencies of copies of birth or death certificates which gave the appearance of being official. According to the hospital associations' statement of clarification, it is unlawful for a maternity hospital to issue a certificate which purports to be or simulates a certified copy or certification of birth. Hospitals may issue certificates which indicate that the births occurred in the hospitals, but, it stated, such certificates should not contain the words "Birth Certificate," "Certification of Birth," "Birth Record" or any other language which would imply an official certificate.

Hospitals will be permitted to use existing supplies of certificates not worded according to Ohio Code for a reasonable period of time.

ESTIMATE SHOWS 504,000 PROFESSIONAL NURSES EMPLOYED IN U.S.—An estimate prepared jointly by the American Nurses' Association, the National League for Nursing and the U.S. Public Health Service shows that an estimated 504,000 professional nurses were employed in the U.S. in January 1960.

The current estimate includes for the first time approximately 3000 nurses in Alaska and Hawaii. The last previous estimate, in January 1958, showed 460,000 professional nurses in 48 states.

The estimate, according to a report from the American Nurses' Association, indicates that the number of nurses employed in hospitals and related institutions has increased over the two-year period, as did office nurses, public

health nurses and nursing educators. There are now 282 full-time and part-time nurses per 100,000 population compared to 268 per 100,000 population in 1958. The ratio, according to the report, is still far below what has been regarded as a reasonable goal of 300 nurses per 100,000 population. The ratios of supply to population indicate an over-all shortage, but do not show the crucial shortages existing in particular areas of nursing practice, notably teaching, supervision and administration, the ANA stated.

RISING MEDICAL CARE COSTS RELATED TO INSURANCE RATES—The U.S. Department of Labor Consumer Price Index for November 1960 reported that increases in hospitalization insurance rates were mainly responsible for the rise in average prices for medical care.

Changes in other elements of medical care costs were relatively insignificant, although a small decrease in drug costs occurred. Prices for prescriptions have gradually declined since June, the index reported, and by November were 1.1 per cent below a year ago.

MICHIGAN BLUE CROSS AND BLUE SHIELD REQUEST RATE INCREASES—In mid-January Michigan's Blue Cross and Blue Shield Plans submitted requests for a composite rate increase of 18.7 per cent. The Plans reported a deficit that is expected to result in a minus-reserve of nearly $2 million by April.

Officials of the Plans said that the increase requests—22 per cent for Blue Cross and 13.5 per cent for Blue Shield—are calculated as the minimum to restore the Plans to a sound financial position and retain it for at least two years. They blamed the need for increases on the rising cost of medical care services and hospitals costs, as well as the increase in admissions.

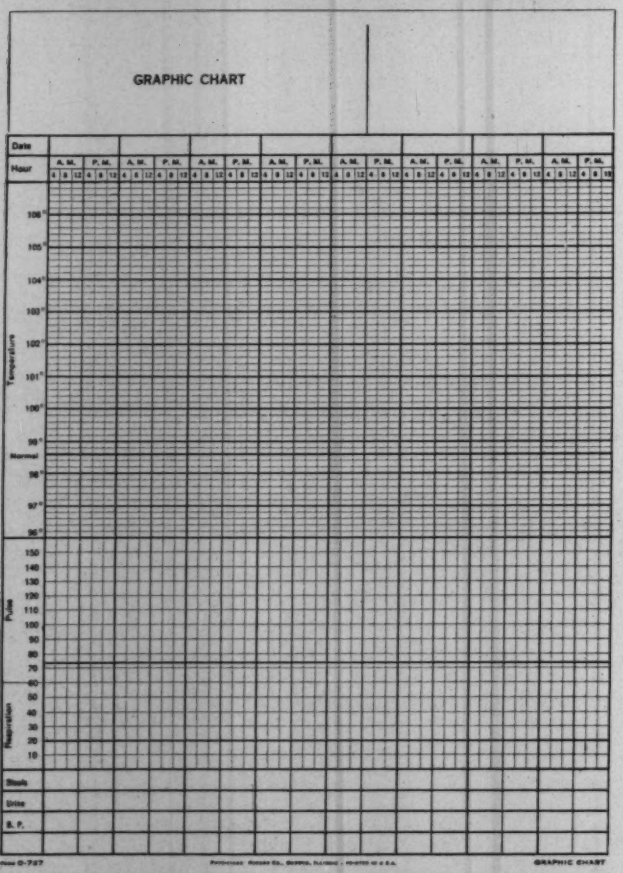
The last Blue Cross rate increase in Michigan went into effect more than two years ago, and Blue Shield's petition in May 1960 for a 19.5 per cent increase was cut to 11.5 per cent. If the present requests are granted they will cost the Plans' 3,675,000 subscribers approximately $42.7 million a year. *(Details p. 118)*

NEW PUBLICATION COMPILES DATA FOR GENERAL PUBLIC—The 1960 edition of "Health, Education, and Welfare Trends" has recently been released. According to the Department of Health, Education, and Welfare, it represents a pioneer effort to acquaint the public with statistical data as an aid to understanding developments and problems in the fields of health, education and welfare.

The publication gives broad coverage to many subjects within the three fields. Among those specific items in the field of health are Measures of Illness and Medical Care, Incidence of Disease, Health Manpower, Private Expenditures for Medical Care and Voluntary Health Insurance, Hospital Facilities and Health Facilities. The information tabulated includes at least preliminary data for 1959 on most subjects. *(Details p. 117)*

Standardized Hospital Record Forms

For Mechanical Addressing Equipment



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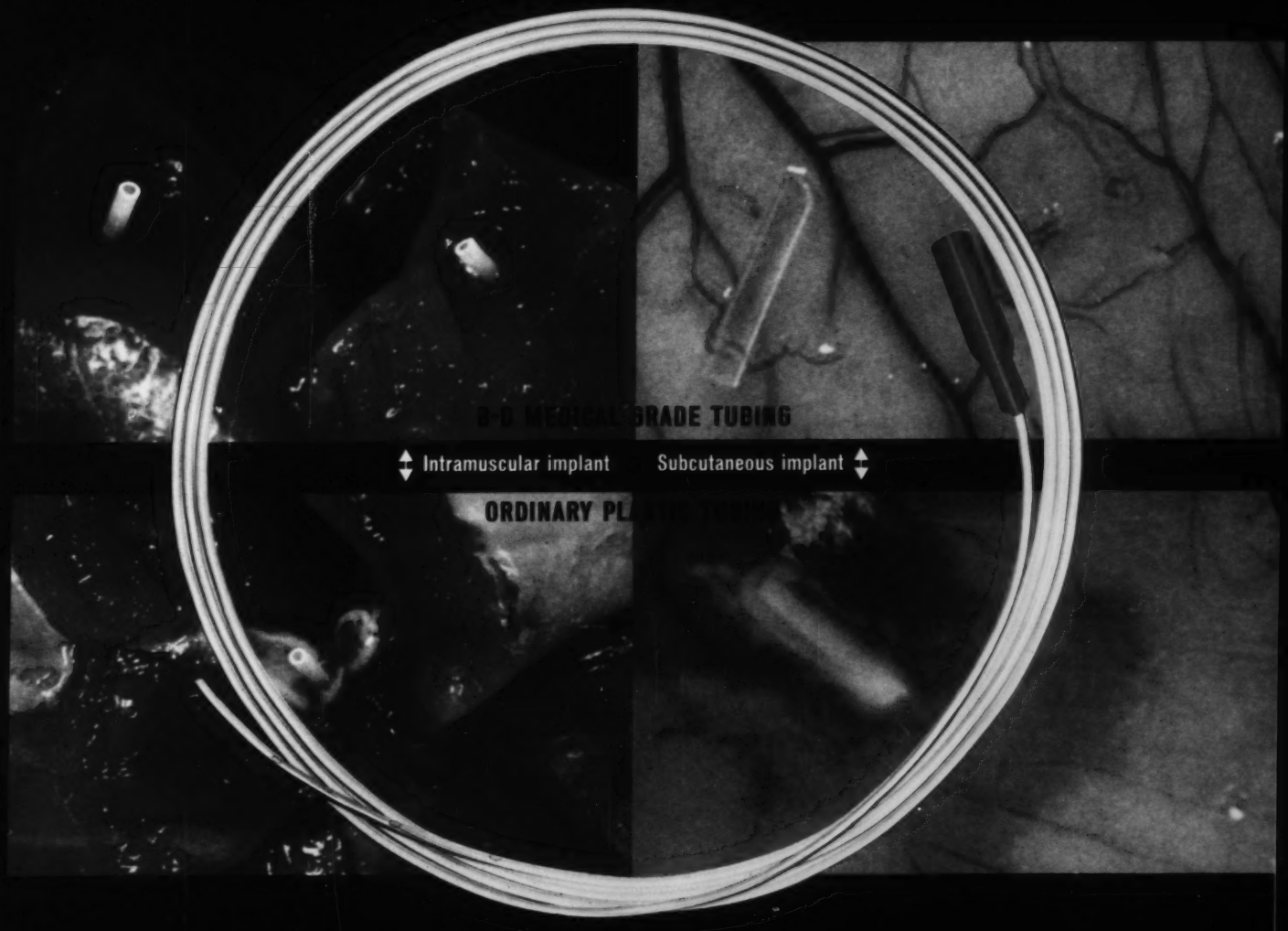

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smooth, unbroken plastic surface...softly rounded distal tips...oval-shaped "eyes" properly positioned for most efficient performance

EFFICIENTLY PACKAGED

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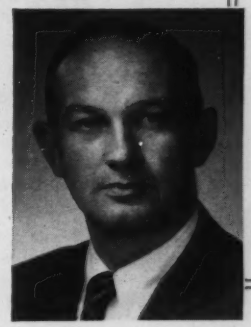
[Advertisement]

What HIGH VACUUM Sterilization can mean for your hospital

by Richard D. Castle



NO. 1 IN A SERIES

This is the first in a series of articles on High Vacuum Sterilization. Its purpose is to examine the significance of this new process. Its author is Richard D. Castle, head of Research and Development, Wilmot Castle Company, Rochester, N. Y. Working with the Drayton Regulator & Instrument Co., Ltd., Castle has developed the OrthoVac* High Vacuum Sterilizer, first models of which will be installed this year in U. S. hospitals.

● The concept of High Vacuum Sterilization was first developed by scientific interests in England. In a research project to evaluate the best system of sterilization for use in a national hospital modernization program, both the continental "partial vacuum" system of air removal and our own concept of "downward displacement" were studied. Both were found deficient. The high vacuum system has since been adopted as the national standard in England.

● We feel most fortunate in being associated with one of the early participants in this program—the Drayton Regulator & Instrument Co., Ltd., of England. Drayton's high vacuum controls are today recognized as the industry standard and the company has already converted over 200 English installations to the high vacuum system.

● The same problem the English have faced and begun to eradicate exists in this country today—namely the inability of the conventional sterilizer to assure efficient, totally effective air removal under all conditions.

● Air, of course, acts as a barrier to steam penetration, slowing and sometimes even preventing the attainment of bactericidal conditions. Under present systems, the speed with which air can be removed, and the certainty of its removal, depend almost entirely upon the size and density of the individual sterilizer load, as well as the manner in which packs have been wrapped and placed in the sterilizer.

● In a test, four seemingly identical packs were placed in varied positions in the chamber of a sterilizer. One reached sterilizing temperature in 5 minutes, another in 25 minutes, with the third and fourth falling in between. Since there has been no way to accurately estimate the time necessary for air removal and heatup in any given case, only gross approximations of overall sterilizing time have been applicable, and these only with addition of ample and varying safety margins. Under these circumstances, it is not surprising to find one hospital routinely sterilizing dry goods for 30 minutes at 250°F, another for 60 minutes, and still another for 90 minutes. Standardization, with the safety and efficiency it brings, has been impossible.

● With the advent of the newly-developed Castle-Drayton OrthoVac High Vacuum System, however, such standardization becomes feasible in this country for the first time.

● *The OrthoVac System utilizes a high-efficiency vacuum pump to draw a near-absolute vacuum in the sterilizer before steam is introduced. So effective is this removal that steam penetration and load heatup are practically instantaneous. Absolute uniformity of temperature is obtained throughout the load within a predictable period. The result is sterilization which consumes far less time, incurs less damage to goods processed, and reduces the process to mathematical certainty.*

● Certain essentials, we have found, are necessary to make the system practical under hospital working conditions. First, the vacuum system used must remove enough air so that no variation in the time necessary for steam-air interchange occurs. This requires a vacuum of less than 20 mm absolute. Furthermore, the vacuum system must be controlled so as to produce precisely the same degree of vacuum during each cycle. To accomplish this, we are using a compensated absolute pressure switch which automatically maintains a precise pre-set degree of vacuum during each cycle, regardless of barometric pressure fluctuation or height above sea level.

● Secondly, to standardize procedure and eliminate possibility of error, a device known as a time-temperature integrator is essential. This device automatically and continually adjusts the exposure period to reflect the temperature in the load, following established thermal death curves. Human error in temperature selection is avoided, fluctuations in steam temperature are automatically compensated for, and the load is exposed to temperature for the minimum time necessary for kill through use of this device.

● Aside from the increased safety of the process, a number of other significant contributions are made by the OrthoVac High Vacuum System.

● A typical "dry goods" cycle takes just 15 minutes from beginning to end, compared to the present-day 60-90 minute cycles. By drawing a "post-vacuum" at the end of the cycle, residual moisture is "boiled" away under reduced pressure and the load returned to its original state of dryness. This not only accelerates drying, but cools by evaporation so that the load may be handled comfortably.

● Owing to the much shortened overall cycle and the virtual absence of air, fast-killing temperatures up to 275°F can be routinely used for fabrics, with considerably less deterioration than by conventional methods.

● Sterilizers may be loaded to capacity—an increase of approximately 25% for every existing "dry goods" sterilizer.

● More effective air removal increases, too, the number of items which can be sterilized in steam. Small bore items such as capillary tubes, needles and goods packaged in permeable material such as paper, nylon autoclave film or cardboard containers, formerly difficult or impossible to sterilize in steam, may now be routinely processed.

● *First production models of the OrthoVac Sterilizer will be installed in hospitals this year. Based on Drayton's experience in England, we have developed the OrthoVac System as a control console which, in many cases, will permit on-the-job conversion of existing "downward displacement" sterilizing equipment. The console design, we feel, will allow hospitals to convert present sterilizers to the safer, more efficient high-vacuum system without spending the additional funds necessary to purchase a complete new sterilizer, or altering present sterilizer facilities to accommodate additional sterilizing equipment.*

For further information on OrthoVac write for Bulletin H-283

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HOSPITAL DIVISION
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accreditation problems

- authenticating reports written by resident house staff
- countersigning reports made by interns, residents
- senior residents' countersigning of reports
- recording of operations, procedures
- review of blood transfusion practices

KENNETH B. BABCOCK, M.D.

Resident house staffs in most states are required to be licensed in their respective states. If this is so, why do the histories, physicals and summaries written by resident house staff physicians have to be countersigned by the attending or ward physician?

This stipulation has been made because these are learning years for the resident house staff. The American Medical Association's Council on Medical Education and Hospitals expresses the same opinion in its *Essentials of Approved Residencies.*

* * *

Must all interns and residents have their histories, physicals and summaries authenticated by the attending physician?

Yes and no. Interns, first and second-year residents and unlicensed physicians should have their histories, physicals and summaries authenticated by an attending physician. Senior residents —for example, third, fourth and fifth-year residents—if licensed, do not have to have their histories, physicals and summaries countersigned.

* * *

May senior residents authenticate histories, physicals and summaries written by interns and first and second-year residents?

Yes, if the senior resident is a licensed physician and if he has been given permission by the medical staff and administration to do so.

* * *

There seems to be great confusion as to whether cystoscopies, sigmoidoscopies, bronchoscopies, etc., should be counted as operations on hospital records. Do you have a solution?

There is no perfect answer, but as a rule of thumb the Commissioners have told hospitals that if the procedure was performed in the operating room suite, it should be called an operation. If the procedure is done elsewhere, such as in an examining room or in the outpatient department, it should not be classified as an operation but as a procedure or test.

* * *

The Joint Commission has stated that it would like a committee of each hospital's medical staff to review procedures for blood administration in its respective hospital and after investigation, to make recommendations to the entire medical staff for improvement of blood transfusion practices. Can you give us some background material on the subject, such as why this should be done and who should do it?

I will quote in part and verbatim from a letter addressed to the Commission by the Joint Blood Council, Inc., and with which the Commission agrees: "Practically all blood transfusions in the United States are performed in hospitals, and most of the transfusion 'accidents' which result in malpractice litigation occur as a result of errors on the part of a member of the hospital staff. There exists a need for an educational program to review these procedures on a local level and to make recommendations for improvement of practice where necessary . . ."

It is recommended:

"1—That each hospital institute a review of all transfusions of blood and blood derivatives by one of the existing committees of the medical staff or by a separate transfusion committee.

"2—That it be the responsibility of this committee to make recommendations to the medical staff concerning the proper use of blood and blood derivatives in that hospital. The formulation of these policies should be consistent with

(Continued on page 126)

This material has been prepared by the Joint Commission on Accreditation of Hospitals, Dr. Kenneth B. Babcock, director. Questions should be sent to the Commission, 200 E. Ohio St., Chicago 11, Ill., or to HOSPITALS, J.A.H.A., for referral to Dr. Babcock and his staff.

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INDICATIONS: All oxytetracycline indications whenever initial or continuing therapy with I.M. injection is indicated. Compatible oral therapy may then be given with Cosa-Terramycin® Capsules or Cosa-Terrabon® Suspension. Effective against both gram-positive and gram-negative bacteria, rickettsiae, spirochetes, and large viruses, Terramycin therapy is indicated in a great variety of infections due to susceptible organisms. These include infections of the respiratory tract, ophthalmic and otic infections, gastrointestinal infections, genitourinary infections, soft-tissue infections, and many others.

ADMINISTRATION AND DOSAGE: For intramuscular injection only. Unless otherwise specified, a dose of 100 mg. every 8-12 hours, or a single daily dose of 250 mg. should be adequate for most mild or moderately severe infections. In *severe* infections, 100 mg. every 6-8 hours or 250 mg. every 12 hours may be necessary. Dosage for infants and children is proportionately less and should be determined in accordance with age and weight of the patient, and severity of infection.

SIDE EFFECTS AND PRECAUTIONS: Aside from occasional mild pain at injection site, adverse reactions (including allergic) have been rare. As with all I.M. preparations, injection should be made within the body of a relatively large muscle. After insertion of needle, aspiration should be attempted before injecting to avoid inadvertent administration into a blood vessel; care should always be taken to avoid injecting into a major nerve or its surrounding sheath. Subcutaneous and fat-layer injection may cause mild pain and induration, which may be relieved by an ice pack.

Use of antibiotics may result in an overgrowth of nonsusceptible organisms—particularly monilia and resistant staphylococci. If a new infection caused by a resistant pathogen appears, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing.

SUPPLIED: *Terramycin Intramuscular Solution* is available in the new 10 cc. multi-dose vial, providing five 2 cc. doses, 50 mg./cc., and in 2 cc. prescored glass ampules, containing 100 mg. and 250 mg., packages of 5 and 100. For maximum rapidity of effect—*Terramycin Intravenous,* in vials of 250 mg. and 500 mg. (buffered with 1 Gm. and 2 Gm. ascorbic acid, respectively). Available for oral therapy: *Cosa-Terramycin® Capsules,* 250 mg. and 125 mg.; *Cosa-Terrabon® Oral Suspension* (preconstituted), 125 mg. per 5 cc. teaspoonful, in bottles of 2 oz. (60 cc.) and 1 pint; *Cosa-Terrabon® Pediatric Drops* (preconstituted), 5 mg. per drop (100 mg. per cc.), bottle of 10 cc. with calibrated plastic dropper. In addition, a variety of other systemic and local dosage forms are available to meet specific therapeutic requirements.

More detailed professional information available on request.

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opinions and ideas

LETTERS TO THE EDITOR

Comments on payola

Dear Sir

Congratulations on the hard-hitting editorial, "Payola Revisited", in the Nov. 16, 1960, issue of the Journal. It's unfortunate that [action by] a small minority on both the hospital and industrial sides of the fence make such comment [concerning bonus and gift schemes] necessary.

It might be well to consider periodic coverage of this theme, not only to place greater emphasis but also to continue to educate the stream of new personnel in both industry and hospital groups.—ROBINSON BOSWORTH JR., *executive vice president, Will Ross, Inc., Milwaukee.*

Food purchasing by bid

Dear Sir

The article, "Shaping Food Purchasing Patterns" by Mrs. Katherine Elman in the Jan. 1, 1961 issue of the Journal, has reaffirmed my belief that setting up standards for quality purchasing is necessary and, in the long run, more economical than purchasing without predetermined standards.

I would like to offer four sets of bidding forms which are used at Jamaica Hospital, L.I., N.Y., and which might be of interest to your readers.

Form 1 is used for bids on all items, except foods. In vertical columns marked A,B,C, and D are placed the names of the vendors. A purchase order number is assigned when an order is given. We ask for date of delivery and terms. These requisitions for supplies were formerly instituted by the department heads but because they were not familiar with proper nomenclatures, these forms are now written in our hospital's purchasing office.

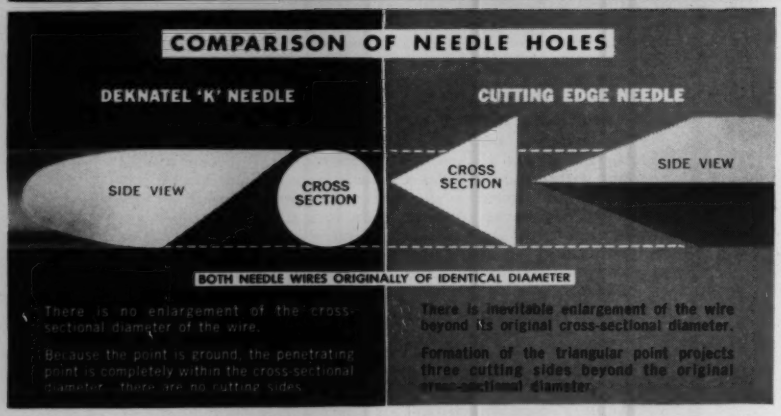
Form 2 is used for ordering meats and poultry. We order on Wednesday for deliveries on Thursday and the following Monday.

Form 3, which lists purchase specifications for staples, is given to the vendor for his bid and returned to our hospital's purchasing office on Thursday afternoon.

Form 4 was developed by the dietary department to recapitulate the prices taken from Form 3 and to record the amounts to be ordered. Since our hospital does not have space to store large quantities, bids for staples are taken weekly.

If any of your readers are interested in seeing our forms, we shall be happy to send them copies.—JOHN P. FLETCHER, *administrative assistant, Jamaica Hospital, Jamaica, Long Island, N.Y.*

WHY SURGEONS SPECIFY
THE ALL-PURPOSE
DEKNATEL 'K' NEEDLE
(U.S. Patent No. 2,869,550)


COMPARISON OF NEEDLE HOLES
DEKNATEL 'K' NEEDLE
CUTTING EDGE NEEDLE
SIDE VIEW
CROSS SECTION
CROSS SECTION
SIDE VIEW
BOTH NEEDLE WIRES ORIGINALLY OF IDENTICAL DIAMETER
There is no enlargement of the cross-sectional diameter of the wire.
Because the point is ground, the penetrating point is completely within the cross-sectional diameter... there are no cutting sides.
There is inevitable enlargement of the wire beyond its original cross-sectional diameter.
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The Deknatel 'K' Needle point is a true scalpel, the sharpest penetrating instrument that can be made. The shaft of the needle easily follows this penetrating point. Cutting sides are not needed to facilitate passage of the needle—the hole is therefore that of a taper point needle. In summation, the Deknatel 'K' Needle has all the advantages of both conventional types and none of their disadvantages.

The Deknatel 'K' Needle is neither cutting nor taper needle but an all-purpose combination of both. O.R. preparation is simplified. A single Deknatel 'K' Needle may be stocked instead of the two formerly required: conventional taper and cutting. With this standardization of one for two, there are savings in inventory and storage space.

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The AIRMASS Alternating Pressure Pad consists of a heavy-gauge, 2-ply plastic pad (full bed length) and a quiet, efficient air pump. Pad contains 2 separate sets of 10 air cells each, running lengthwise, which alternately inflate and deflate in 3 minute cycles.

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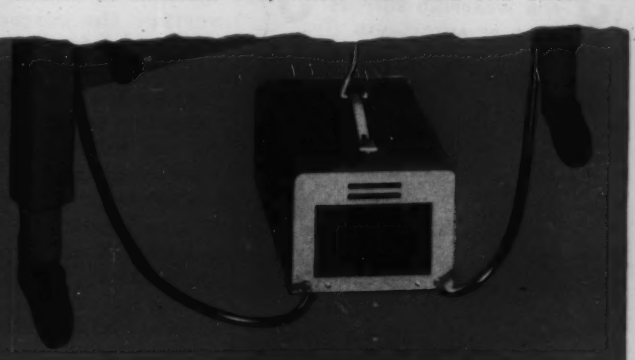

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Checking daily charges

What methods can be used to check daily service charges to patients?

There are a number of ways to check daily service charges to patients, but the selection of a particular method will depend on the hospital's accounting and billing procedures.

One method is to use the midnight census report to create the charge. To do this, the business office checks the inpatient account file against the census sheet to determine (1) that an account has been prepared for every patient; (2) that all transfers of patients have been recorded on their account to ensure that the proper rate is being charged, and (3) that all accounts for discharged patients have been removed from the account file.

A second method is to post the daily service charge automatically to each patient's account daily. At the time of discharge, the cashier verifies the correctness of the amount posted by counting the number of days the patient occupied each class of room and by extending the appropriate amounts for the number of days in each class of room.

The creation of a posting median is also beneficial as then there is a means of checking against machine totals and the midnight census for each day.

—RAY S. MATYLEWICZ

Organizing tissue committee

How should the tissue committee of the medical staff be organized to meet the requirements of the Joint Commission on Accreditation of Hospitals?

One of the primary functions of the organized medical staff of the hospital is the analysis and review of the clinical work done in the hospital. The organizational structure used to accomplish this is a matter for local decision.

The essential feature is adequate review and analysis by the medical staff of all types of treatment given in the hospital. Documented evidence that this is being done will establish that the organized medical staff is meeting its obligations in a way which satisfies the requirements of good medical practice in the hospital.

If the tissue committee limits itself to considering tissue removed at operation, in the light of preoperative, clinical and pathological diagnoses, then cases not productive of tissue should be reviewed by some other appropriate group. The actual organization set up to accomplish this is of secondary importance.

Detailed suggestions for effectively organizing medical staff committees to exercise clinical review and control can be found in the Hospital Accreditation References published by the American Hospital Association and the bulletins issued by the Joint Commission on Accreditation of Hospitals, 200 E. Ohio St., Chicago 11, Ill.

—FREDERICK N. ELLIOTT, M.D.

Collecting specimens

How should assignment of activities to graduate nurses in a hospital be made? Should the collection of specimens be one of their assigned activities?

The assignment of activities to graduate nurses in a hospital is based on traditional practices and/or medical staff approval and delegation.

Collection of specimens in hospitals without a house staff is usually the responsibility of the attending physician and/or nurses. In teaching hospitals, interns, residents or physicians customarily collect gastric specimens.

There is no standard rule governing assignment of such activities, but variation in practice is found depending on availability and preparation of personnel. The literature is silent on whether collection of specimens is a rightful responsibility of nurses or laboratory technicians.

—ELEANOR C. LAMBERTSEN, R.N.

The answers to these questions should not be construed as being legal advice. Hospitals with legal problems are advised to consult their own attorneys.

[Advertisement]

Can you afford to give away medication?

As hospital costs mount, it is becoming increasingly evident that the beneficiaries of hospital services—the patients—must assume their fair share of the costs incurred. For this to occur, the hospitals must be able to account scrupulously, either to the patients or to the various prepaid hospital plans, for all services and medication.

Old-style injections too complicated

Because accounting and billing for medication withdrawn from multidose vials has been so difficult and time consuming, many hospitals have virtually been forced to write off the cost of common injectables or, at best, to estimate them. Yet it is clear that few hospitals can afford to give away medication or to rely on estimates, which are often unacceptable by the prepaid plans.

TUBEX lets you charge fairly

The TUBEX system provides individual, unitized doses of medication in tamper-proof cartridge form. It's an easy matter to keep track of medication dispensed and administered. ***You know just what each patient received, and precisely how much. And you can charge accordingly, with unassailable fairness.***

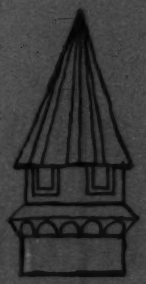
The need to charge accurately and as completely as possible is being met by the TUBEX system in more and more hospitals across the nation. Typical of the accolades the system has won is the following, excerpted from *The Bulletin of the Parenteral Drug Association:*

The charge made to the patient should include all services rendered. When most of these services are built into the product by the supplier—guaranteed identified contents and dosage, guaranteed sterility, plus simplified record keeping and control—and included in a single purchase price paid to the supplier, there is no problem in justifying the charge to the patient. It is a charge that can easily be backed up by records, and it does not strain the credulity of any investigator.—Crohn, L.B.: The Bulletin of the Parenteral Drug Association, p. 23, March-April, 1960.

If you want to learn more

Your Wyeth Territory Manager will be glad to give you all the details about the TUBEX system. Or, write to Wyeth Laboratories, P.O. Box 8299, Philadelphia 1, Pa.

QUEBEC by Ernest Henenfeld, opposite page, is available in a handsome wide-margin print from Professional Services, Abbott Laboratories, North Chicago, Illinois



In picturesque QUEBEC, too, Pentothal is an anesthetic of choice

Physicians in Quebec speak two languages, but in both they agree on Pentothal. ✣ They like its smooth induction with absence of delirium . . . the easy moment-to-moment control over depth of narcosis . . . the patient's rapid emergence from unconsciousness . . . the relative freedom from postoperative nausea. ✣ They know that Pentothal is the one intravenous anesthetic proved by a quarter century of practical clinical experience. ✣ We invite you, too, to join the physicians of 75 lands who prefer Pentothal and specify it regularly.

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Ureaphil is an intravenous form of urea, recently introduced by Abbott for use wherever prompt diuresis is important. Response to Ureaphil can prove dramatic, even life-saving, in cerebral edema or oliguria following burns, surgery, and trauma.

Ureaphil provides the doctor a classically simple way to eliminate excess water. It disperses rapidly in the body fluids, and quickly finds its way to the renal tubules. Here it promptly cuts reabsorption of water by raising osmotic pressure.

This mechanism is normal and physiologic. It often produces diuresis even where potent mercurials become ineffective.

Ironically, though urea's diuretic efficacy has been known in oral form for a century, almost nobody used it. It tasted terrible, was hard to get down and keep down.

This problem is eliminated in intravenous Ureaphil, and the product is proving invaluable for difficult cases.

Ureaphil is indicated in cerebral edema before or during surgery, and sometimes where surgical intervention is not needed; and to counteract oliguria following burns, surgery, and trauma. It is useful after prostatectomy, when an abundant flow of urine may eliminate need for bladder irrigation. It is helpful, too, in edema due to heart failure, especially where mercurials cease to produce the desired effect

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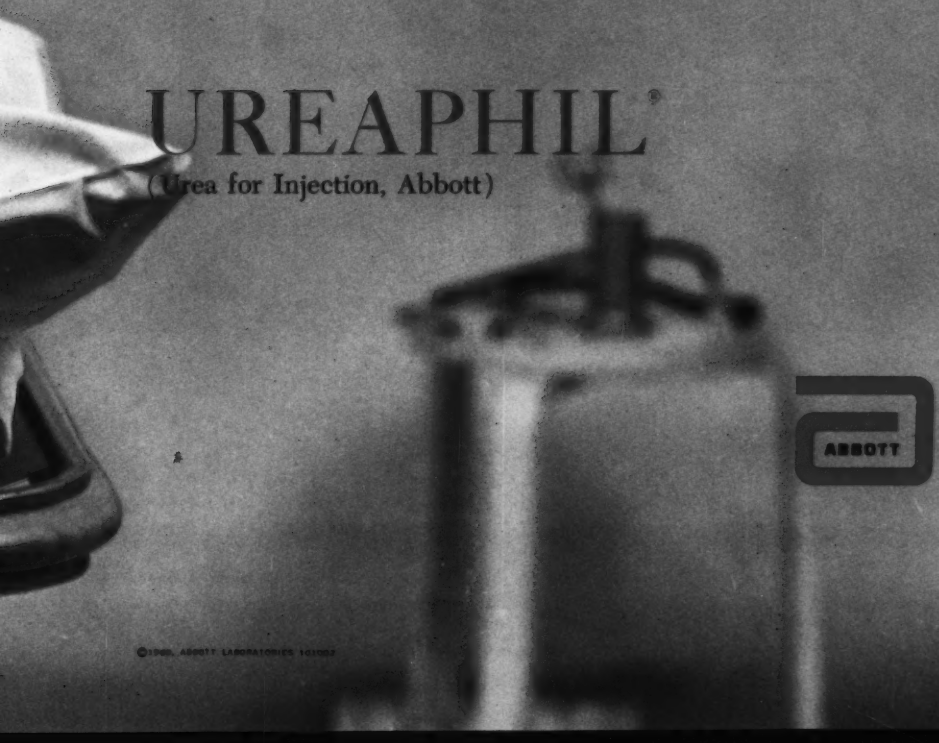

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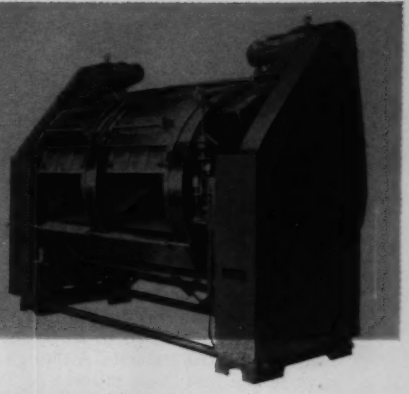

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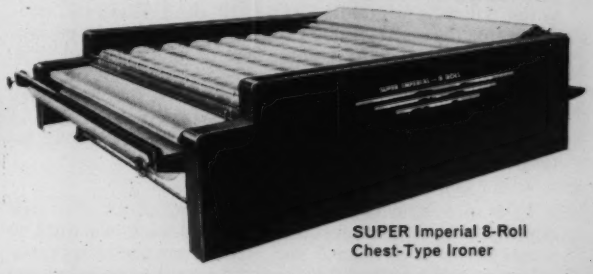

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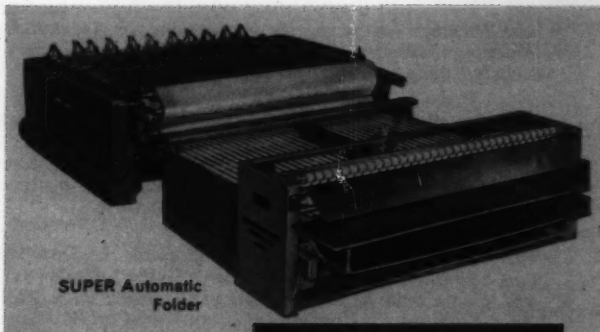

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Lehn & Fink
PROFESSIONAL DIVISION

staph newsletter

TENTH OF A SERIES WITH SIGNIFICANT SUGGESTIONS FOR CONTROLLING CROSS INFECTIONS

HERE it is the season again to be on the alert against spread of flu and flu-like illnesses which, all too frequently, lead to staphylococcal pneumonia and death in high-risk patients. Although the influenza epidemic wave of the first three months of 1960 was not as severe as the Asian-flu winter of 1957-1958, the USPHS still considers that it caused 26,000 excess deaths during the period. Of these, 80% were in patients over 65 years old and 90% were attributable either to pneumonia-influenza or complications of renocardiovascular diseases. Unlike many viruses, the influenza virus can and does persist for days in virulent form in the environment unless destroyed by intensive disinfection measures.

Last month, when we first told you about our new Amphyl® Spray Disinfectant and Deodorant, we were so intent on its convenience and effectiveness as a spot disinfectant and air deodorant that we forgot to mention one of its very good features. This is that it does not leave an oily or sticky residue. To demonstrate this, one of our technical representatives applies Amphyl Spray to his white shirt cuff! For surfaces, you can demonstrate it on a glass door or mirror—but why not spray it right on to a door handle or bed side table where it can go to work as the disinfectant it is? Would you like our descriptive folder and bacteriologic reports on Amphyl Spray? If so, please write us.

"Staphylococcal enteritis or staphylococcal diarrhea among our hospitalized patients is a source of concern to us, since we do not know its exact relation to potentially fatal pseudomembranous enterocolitis, to the possible role of intestinal staphylococci in serving as a reservoir for staphylococcic infection of other patients in our hospitals, or to the transfer of these intestinal organisms to other parts of the body where their presence may present serious problems, such as wound infections, pneumonia and septicemia."

Drs. Dearing and Needham of the Mayo Clinic and Mayo Foundation made the above comments after a two-year study of 243 consecutive, hospitalized patients whose stool cultures revealed the presence of Staph. aureus. (J.A.M.A., Nov. 19, 1960) Although none of the seven stated purposes of this study was evaluation of the extreme dangers of cross infection, awareness of this potential is evident throughout the report.

In the care of such patients, aseptic housekeeping measures are essential to help avoid autoinfection of the patient, spread of organisms to other patients, and infections of personnel. Thorough disinfection of floors and equipment, as well as linens and blankets, is dependably accomplished with any one of the L&F refined phenolic disinfectants—Amphyl®, O-syl®, and Lysol® disinfectants or Tergisyl®, our detergent-disinfectant. As you know, all are widely microbicidal, including staphylocidal, pseudomonacidal, tuberculocidal and fungicidal. Specific recommendations for using each product are available for individual or group instruction. If you need multiple copies for teaching purposes, just let us know. We'll be glad to send them.

If you're wondering whether it's still important for a disinfectant to be a tuberculocide, consider this statistic from the Virginia Public Health Department. In the years 1957 to 1959, 42% of the tuberculous individuals who died were first identified as such on the death certificate.

Many long-range reports now being published confirm that, in most hospitals, staph infection exists at an endemic level. Goal of contamination control measures is to lower that level and to prevent emergence of epidemics or, should they occur, to curtail them quickly. Isolating patients admitted with staph infections, as well as those developing staph infections after admission, is now widely recommended. Frequently, the success of such units in preventing spread of infectious organisms throughout the hospital depends upon specific and dependable disinfection procedures within the isolation unit. *Use of Amphyl® on floors, walls, furniture and fixtures and in laundering blankets, linens, and curtains will destroy these offending organisms. Our new literature covers specific instructions for Amphyl disinfection of isolated units. Bacteriologic data is, of course, included. May we send it to you?*

℞ for eliminating staphylococci from 50 blankets: add 1 gallon of Amphyl® to 100 gallons of water, rotate for 3 minutes, soak for 10 minutes, add soap or detergent and follow usual washing procedure. If residual antibacterial effect is desired, add 1% Amphyl to last rinse.

If there's any doubt in your mind about the basic role that bactericidal floor cleaning can play in infection control, please write us for a reprint of the article "The Floor As A Reservoir Of Hospital Infections", by Carl W. Walter, M.D., and Ruth B. Kundsin, Ph.D., as published in Surgery, Gynecology & Obstetrics, October, 1960. Graphic comparisons are made between bacterial counts when floor disinfection is done at 30-day intervals and 24-hour intervals. The difference is significant.

Have you a baffling contamination control problem in your hospital on which we might help? Although we realize that disinfection is only one part of the complete control program, as you know, it is an important one. Our research laboratories and technical advisers are ready to help and I, personally, would like very much to hear from you.

Charles F. Manz
General Sales Manager
Professional Division

LEHN & FINK PRODUCTS CORPORATION
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HOSPITALS
JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION

editorial notes

—time for the spurt

MANY HOSPITALS and local hospital groups, looking realistically at the present foreign medical graduate situation in the United States, are taking action to improve it. Their efforts have been directed mainly toward developing training programs for their foreign-trained house officers. These programs have been developed through the planning and cooperation of hospital administration, attending staffs, medical school faculties, local hospital councils, departments of health and other interested agencies.

These programs have concentrated largely on the basic medical sciences, such as anatomy, physiology, chemistry and other fundamental subject areas. The programs consist of lectures, clinical and laboratory sessions, demonstrations and conferences. In some instances, attendance by foreign medical graduates is compulsory; in others, it is not.

Currently active programs have been tailored to meet the needs of the uncertified or unlicensed foreign-trained house officer. In some cases, a deficiency in English led to the inclusion of the teaching of English in the program. Program content has been selected with a view to helping uncertified or unlicensed foreign medical graduates pass the April 4, 1961, examination of the Educational Council for Foreign Medical Graduates (ECFMG).

Hospitals planning to conduct such programs should keep two dates firmly but separately in mind —April 4, 1961, when the next ECFMG examination will be given, and June 30, 1961, when the educational exchange visas of unlicensed foreign medical graduates who have not passed the ECFMG examination will expire.

Although June 30, 1961, has been referred to as the deadline date—and in one sense it is—the immediate deadline for hospitals who want to assist their uncertified or unlicensed foreign-trained house officers in gaining the proper credentials is April 4, 1961. Any training program or educational effort, to be effective, must accomplish its purpose *prior* to April 4. Training or education after this date may make better house officers, but it will not help foreign medical graduates to pass the ECFMG examination.

—radio channels for hospitals

MORE THAN three years of effort by the American Hospital Association to obtain eligibility standards and reserved frequencies adequate to meet the radio needs of United States hospitals bore fruit when the Federal Communications Commission (FCC) announced last December that it had formulated new rules governing eligibility and had set aside five radio channels for the exclusive use of hospitals and hospital-connected vehicles.

The AHA foresaw the need for radio channels exclusively for hospital use some years ago. The ordinary, day-to-day volume of traffic on commercial telephone, telegraph and radio means of communication is such today that hospitals are hampered in even minor emergency situations. This being so, the necessity for an adequate and instantly available means of communication in event of a community-wide, or a national, disaster is crystal clear.

It should be well understood that the FCC's action assumes prompt and definite hospital action to obtain and use these exclusive frequencies. This calls for intelligent planning by administration, the medical staff and other interested parties.

The radio communication facilities must be selected, the area to be served must be mapped out, the method of operation of the system must be considered and the number and types of units needed must be chosen.

Clearly, this cannot be done haphazardly or in impromptu fashion because (1) equipment is costly and installation expensive; (2) the system must operate properly to be useful to the hospital and its community, and (3) changes to rectify the results of careless planning will cost more money, and will take more time because FCC approval will be needed for any modifications.

The feature, "What the New FCC Regulations Mean: Questions and Answers on Hospital Radio Communications," on page 42 of this Journal, answers a number of pertinent inquiries about the entire topic.

Hospitals undertaking to establish radio stations will have a great opportunity to improve their service to their communities. They will also assume serious responsibilities. What is important now, however, is that hospitals should grasp the opportunity which long and persistent efforts have put within their reach.

WHAT THE NEW FCC REGULATIONS MEAN

QUESTIONS ON HOSPITAL

The Federal Communications Commission amended its rules, effective Dec. 1, 1960, to make hospitals eligible to use radio communications, both in connection with their day-to-day activities and in time of disaster. This article anticipates some of the practical questions that will undoubtedly arise as hospitals begin applying for, installing and using appropriate radio facilities.

Initially, it must be clearly understood that *all* radio transmitters, whether they are at fixed locations, in vehicles, or of the hand-carried type, must be operated under and in accordance with proper station authorizations granted by the Federal Communications Commission and in accordance with the pertinent rules of the Commission. It is, therefore, equally essential that any hospital which proposes to operate a transmitter obtain and have available at all times a copy of Part 10 of the FCC's Rules and Regulations, which governs radio communications by hospitals. The questions and answers that follow are not intended to be a substitute for careful study of, and frequent reference to, these rules. Rather, they are intended to point out some of the more important aspects of hospitals' use of radio.

EXPANDED ELIGIBILITY

Q. What hospitals are eligible to use radio communications under the new rules?

A. Generally, all hospitals are now eligible—proprietary as well as public and nonprofit—except that a station license will *not* be granted to any hospital of which any officer or director or trustee or owner of one-fifth or more of the capital stock is an alien or representative of a foreign government. (The new rules define eligible hospitals as "institutions or establishments offering services, facilities and beds for use beyond 24 hours in rendering medical treatment.")

The new rules have also expanded the eligibility of ambulance operators to use radio communications. Application to use radio for ambulances must be made by the organization which owns and operates the ambulance. Thus, in the case of ambulances which are owned and operated by a hospital, the hospital would apply for the radio license. In the case of ambulances owned and operated by nonhospital groups, such groups would apply for the radio license. In the case of applications by nonhospital ambulance groups to use frequencies reserved for hospitals, such groups must, in order to use a hospital frequency, make a showing in their applications "that they render coordination and cooperation with a hospital authorized" to operate on the frequency in question.

Q. What sort of messages may hospitals transmit by radio?

A. Hospitals are eligible to use radio "only for the transmission of messages necessary for the rendition of an efficient hospital service".

Q. Where may radio transmitters which are licensed to hospitals be located?

A. Although the FCC's rules have no specific limitations as to the location of hospital transmitters, the need which the new rules were intended to accommodate was for fixed, or base, stations located at hospitals with a number of mobile transmitters located in the automobiles of hospital administrative personnel and hospital staff physicians,* as well as in hospital-owned vehicles, including ambulances owned by the hospital.

USE OF HAND SETS

In addition, the new rules authorize the use by hospitals of so-called "hand-carried" or "pack-carried" radio sets in connection with the "rendition of an efficient hospital service". This authorization contemplates, for example, the location of portable transmitter-receivers in the homes of the administrator and other key staff personnel, including the medical staff, in order to consult or summon them in emergencies. Moreover, there are on the market now some portable transmitter-receiv-

*In addition, the order promulgating the new rules indicates that hospitals may, by entering into an appropriate agreement for sharing radio facilities, authorize the placing of mobile units in the automobiles of nonstaff physicians. A hospital which does enter into such an agreement with a nonstaff physician must file one copy of it with the FCC and retain a copy for its permanent files.

AND ANSWERS

RADIO COMMUNICATIONS

ers which are so small that they could conveniently be carried in the coat pocket of hospital personnel or staff physicians. Such radio sets often have an effective range of several miles, depending, of course, upon the nature of the terrain over which the signal must travel and the amount of interference that exists on the particular frequency.

The order leaves to the hospital licensee the designation both of the persons on its administrative staff and of the physicians who may be permitted use of automobile or hand sets on the hospital frequency. It should be noted, however, that the equipment may be used only for "messages necessary for the rendition of an efficient hospital service", and this limitation will guide the selection of both administrative and professional personnel whose use of radio will be sufficient to warrant the expense.

The same order that makes hospitals eligible to use radio communications makes other provision for messages pertaining to the nonhospital practice of physicians, including staff physicians. If the physicians of a community desire to establish a radio service for messages of this type, it will ordinarily be initiated through the local medical society. It is unlikely that, except in rare situations, hospitals will avail themselves of the provision relating to nonstaff physicians.

Q. How many transmitters may a single hospital have?

A. Normally, each eligible hospital will be authorized to operate only one base (fixed) station and a number of mobile units not in excess of the number of vehicles actually engaged in rendering an efficient hospital service. In addition, there is no limitation in the rules on the number of hand- or pack-carried mobile units which a single hospital may employ.

Q. May a hospital transfer its FCC radio authorizations?

A. Such authorizations may be transferred only upon proper application to and with the *prior* consent of the FCC.

Q. What procedures must be followed to obtain a radio station authorization and for commencement and continuation of operations?

CONSTRUCTION PERMIT

A. 1. The first step is to apply to the FCC for a permit to install a new radio station on FCC Form 400.** Such permit is called a "construction permit". The instructions which accompany FCC Form 400 should be followed carefully. Again, however, they are not an adequate substitute for familiarity with the FCC's rules. A separate Form 400 must be submitted for each new station authorization for a base or fixed station, and for each group of mobile units (to be located in vehicles), except that the application for mobile units may be combined with that for a single base station where the mobile units will operate only with that base station. A hospital's *initial* construction permit application must be accompanied by a statement describing the radio communication facilities desired, the area to be served, the proposed method of operation and the number and classes of units required, including the number of units to be placed in automobiles and the number of hand- or pack-carried sets which the hospital wishes to use. The statement must also show that the hospital is eligible to use radio, under the standard described above.

2. When the hospital obtains a construction permit, *and not before*, it may proceed with the installation of the radio facilities which are specified in the construction permit issued by the FCC. From the date of grant of the construction permit, hospitals will normally have eight months within which to complete construction of the facilities. However, if the facilities are not ready for operational use on or before the expiration of the eight-month period, an application for extension of time to construct may be filed on FCC Form 400-A.

3. Upon completion of the installation, the hospital must notify the FCC engineer-in-charge of the local radio district of the date on

**The completed application form should be sent to Secretary, Federal Communications Commission, Washington 25, D.C.

which the transmitter(s) will first be tested. This notification may be made on FCC Form 456 and must be made at least two days before the test date. No reply from the radio district office is necessary before tests are begun.

4. Since the FCC generally treats an application on FCC Form 400 as a simultaneous application for a construction permit and a station license, a hospital will usually obtain a construction permit and license for its stations simultaneously. It should then notify the FCC engineer-in-charge of the local radio district of the date on which the transmitter(s) will be placed in operation, using FCC Form 456.

5. If, however, the hospital receives initially only a construction permit, it must, after testing but on or before the date when the station is used for full operational purposes, mail to the FCC in Washington, D.C., an application for a station license (Form 400). The hospital may then proceed to use the station(s) for full operational purposes pending FCC action on the license application.

CHANGES IN FACILITIES

6. Once a station is authorized, it is necessary to obtain prior FCC consent before making changes in the facilities that will result in operation which is inconsistent with any of the terms of the current authorization. Generally speaking, application for consent to such changes must be made on FCC Form 400. Authority to make the following types of changes, however, may be requested on FCC Form 400-A (a simpler form): (a) a change in the authorized location of a transmitter; (b) reduction in antenna height; (c) reduction in the over-all number of transmitters authorized for mobile use; (d) an increase in the over-all number of transmitters authorized for mobile use, and (e) an extension of the time for completion of construction.

Where a proposed change will not involve a departure from the terms of the station's authorization, it may be made without prior Commission approval. An example of such a change would be the substitution of a new type of transmitting equipment (when such equipment is on the FCC's "type accepted" list, and when it would employ the same type of emission as the old, and would not exceed the power limitation in the station's authorization).

Q. How may FCC Forms be obtained?

A. Requests for standard application forms for the Special Emergency Radio Service (under which hospitals will be licensed) and any correspondence related to applications should be addressed to the Secretary, Federal Communications Commission, Washington 25, D.C., or from any of its district offices. Applications should be filed at least 60 days in advance of the date of desired FCC action.

Q. Who may sign FCC applications?

A. One copy of each application must be signed under oath or affirmation in accordance with the following:

1. Applications filed on behalf of hospitals owned by governmental entities (such as states, municipalities, etc.) must be signed by such duly elected or appointed officials as are competent to do so under the law of the jurisdiction.

2. Applications filed by hospitals not owned by governmental entities must be signed by the individual owner, if individually owned; by one of the partners, if the hospital is owned by a partnership; by an officer, if the hospital is owned by a corporation; or by a member who is an officer if the hospital is owned by an unincorporated association.

Q. What is the duration of a station's license?

A. Initially, each station license is issued for a period of from one to five years. Thereafter, upon proper application (on FCC Form 405-A during the last 60 days of the license term), the license may be renewed for five years.

TECHNICAL LIMITATIONS

Q. What technical limitations (frequencies, power, antenna height, etc.) are imposed upon the radio facilities which hospitals may use?

A. 1. Five frequencies—155.325 mc., 155.340 mc., 155.355 mc., 155.385 mc., and 155.400 mc.—have been reserved for the exclusive use of hospitals. In addition to these five exclusive frequencies, hospitals may use a number of other frequencies used in common by all classes of Special Emergency radio licensees. The FCC's rules set forth all of these frequencies. In applying to the FCC for permission to install radio facilities, hospitals must specify, in the application form, the particular frequencies upon which they desire to operate.

The five frequencies reserved for hospitals may also be used by ambulances which, in their applications, make a showing that they render coordination and cooperation with a hospital authorized to operate on the frequency for which the ambulance is applying.

2. The rules also specify limitations as to types of emission and maximum band widths (in kilocycles) which are permissible in the Special Emergency Radio Service. Hospital administrators should become familiar with these and other technical limitations concerning the radio facilities which they may use before investing in equipment.

3. Hospital radio stations may use no more power than the minimum required for satisfactory technical operations, depending upon the size of the area to be served and local conditions which affect radio transmission and reception. If the station causes harmful interference to other stations, the Commission may order a change in power or antenna height, or both. In addition, there is a maximum "plate power input" prescribed for transmitters operating on various frequencies. For the 150 mc. band, in which the frequencies reserved exclusively for hospitals fall, the maximum plate power input is 600 watts. The FCC rules should be consulted to determine maximum permissible power if other frequencies are to be used.

4. All transmitters must be located so that only authorized persons have access to them.

5. Hospitals must establish procedures for checking to ensure that its transmitters maintain their operations on assigned frequencies and that maximum permissible power is not exceeded. These

checks must be made regularly at specified times and may be made by a qualified engineering service.

6. A list of radio equipment acceptable for licensing is available for inspection at the FCC headquarters and at its various field offices. Generally speaking, transmitters used by hospitals must be of a type that is included in the list. An applicant may, however, request special FCC acceptance of a transmitter that is not on the list.

OPERATING TRANSMITTER

Q. Who may operate a hospital's transmitters?

A. Every hospital licensed under the order must have on its staff enough persons licensed as commercial radio operators (of any class) to have one such person on duty whenever the base station is in operation. The qualifications required to obtain the necessary operator permit are not stringent. Periodic checking of the equipment must be performed by a first or second class operator, but this may be done by other than a member of the hospital staff. Operation of mobile transmitters on the hospital frequencies does not require a license. Information concerning eligibility and requirements for all types of radio licenses is contained in Part 13 of the FCC's Rules and Regulations, copies of which may be obtained from the FCC.

During the course of normal rendition of service, when transmitting on frequencies above 25 mc., an unlicensed person may operate a hospital's *mobile* transmitters, if he has been authorized by the hospital to do so. As to base (fixed) transmitters, they must be operated in accordance with the following:

1. From a "control point" (an operating position which is under the control and supervision of the hospital, and at which required equipment monitoring facilities are installed, and at which an operator responsible for the operation of the transmitter is stationed),* only a person holding a commercial radio operator's license of any class issued by the FCC may operate the base (fixed) transmitter;

2. From a "dispatch point" (a position from which messages may be transmitted under the supervision of a "control point" operator and which may be installed without FCC authorization,** an unlicensed person may operate a base (fixed) transmitter if he has been authorized to do so by the hospital, and if such operation is under the direct supervision and responsibility of a person holding a commercial radio operator's license of any class issued by the FCC and who is on duty at the "control point" of the transmitter.

Q. Are there specific requirements with regard to posting and retaining operator and station licenses?

A. Yes. The original (not a photocopy) of the license of the base (fixed) station operator must be posted or kept immediately available at the place where he is on duty as an operator. In addition, the current license of each base (fixed) transmitter must be posted at the principal control point of the transmitter, and a photocopy of the authorization must be posted at all other control points listed on the license. Although current licenses for mobile transmitters and base transmitters authorized to be operated at temporary locations need not be posted, they must be retained as a permanent part of the hospital's records. Also, a filled-out Transmitter Identification Card (FCC Form 452-C) must be attached to each mobile transmitter (including hand- or pack-carried units) and to each base transmitter authorized for operation at a temporary location.

Q. Are hospitals required to keep records in connection with the operation of their transmitters?

A. Yes. Hospitals must keep the following records:

1. The results and dates of all transmitter measurements required by the FCC's rules.

2. When service or maintenance duties are performed, the responsible operator must sign and date an entry in the station record indicating the details of the work performed, his name and address, and the class, serial number and expiration date of his operator's license.

3. For all base (fixed) stations, the person or persons responsible for the operation of the transmitting equipment must sign (not initial) the station record each day, both when coming on and when going off duty.

It should be noted that hospitals must have their transmitters and records available for inspection by the FCC at any time.

CONELRAD

Q. What obligations do hospitals with radio authorizations have in connection with CONELRAD?

A. All hospital radio transmitters are required to provide for receiving the CONELRAD Radio Alert and to take appropriate action to minimize the navigational aid which may be obtained by an enemy from the electromagnetic radiations emanating from radio stations, while simultaneously providing for continued radio service under controlled conditions when such operation is essential to the public welfare. CONELRAD requirements are set forth in detail in the FCC's rules.

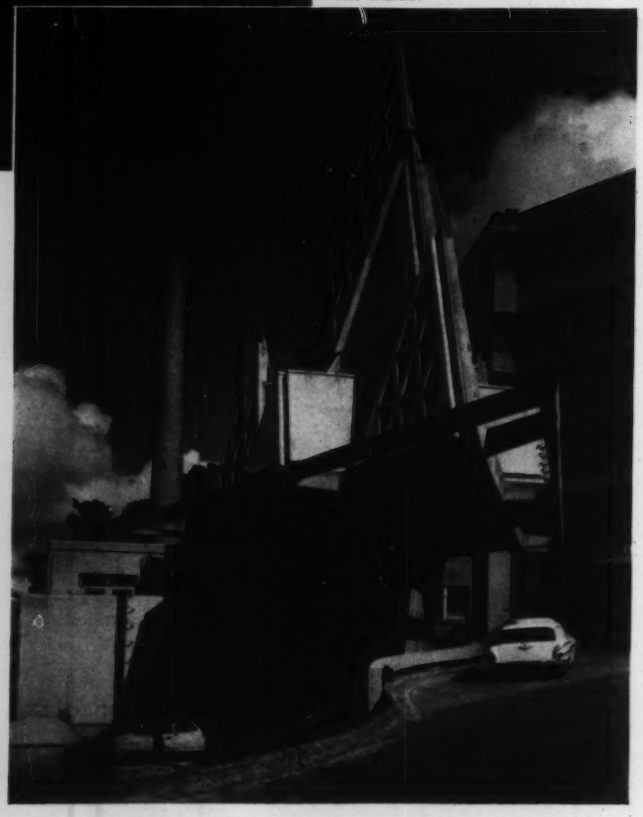
VIOLATION OF RULES

There are a great many responsibilities that accompany an authorization to use radio communications. Hospitals are urged to make certain that they discharge those responsibilities fully. If, however, a hospital does appear to have violated a provision of the Communications Act or one of the FCC's rules, it will receive written notice from the FCC calling the facts to its attention and requesting a statement. Within 10 days of the receipt of such a notice, the hospital must send its written answer in duplicate direct to the FCC office originating the notice. If the answer takes more time, the notice must be acknowledged within 10 days and a full answer made as soon as possible with an explanation of the delay. Any hospital which receives such a notice of violation should immediately consult the FCC rules and take action to ensure compliance in the future. ■

*If a hospital's base (fixed) transmitter is operated from a point within the hospital itself, at which the above mentioned facilities are installed, this operation is from a "control point."

**If facilities are installed that permit operation of the hospital's base (fixed) transmitter from a point distant from the transmitter and the equipment monitoring facilities, such operation is from a "dispatch point."

AS STRIKING by night as by day, the new chapel of the Moline (Ill.) Public Hospital stands separate from the hospital but is joined by a 60-foot closed bridge. Night illumination is provided by 45 floodlights that bathe the exterior and shine through colored glass pieces to the inside. The 30-foot lantern at the apex is lighted from the inside.



'A Watch in the Night'

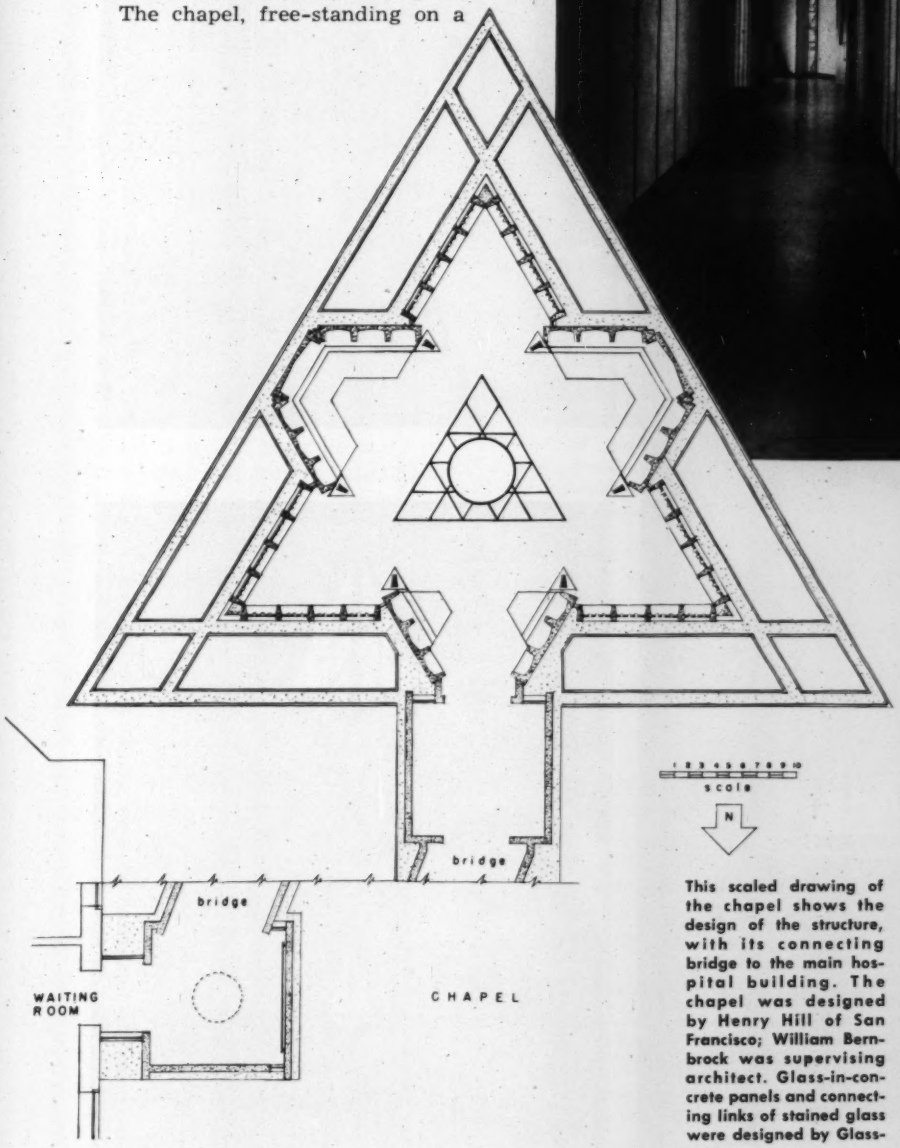
STANDING like a giant lantern on a slope behind the hospital is the new interdenominational chapel at Moline (Ill.) Public Hospital. The chapel, a gift to the hospital, will provide a place for quiet meditation and prayer for patients and their visitors.

The chapel is unusual from an architectural standpoint, but it is also unusual in that it is separate from the hospital yet readily accessible from a point adjacent to a waiting room.

Resemblance of the building to a lantern was not an accident. The design was meant to be an architectural expression of the 90th Psalm, the key phrase of which is ". . . and as a watch in the night".

The chapel, free-standing on a 30-foot pedestal, is entered by means of a 60-foot-long elevated corridor, which not only provides access but space for "pacing". At the entrance to the corridor is mounted a large metal plaque bearing the 90th Psalm.

THE 90TH Psalm cast in metal is mounted at the entrance to the passageway leading to the chapel.



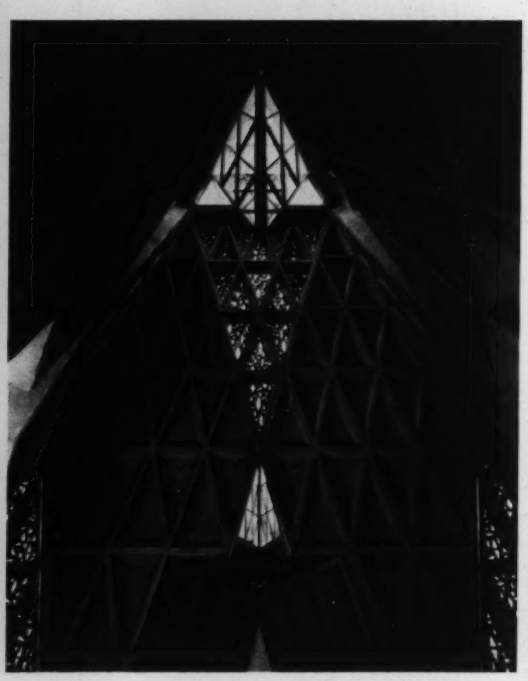
This scaled drawing of the chapel shows the design of the structure, with its connecting bridge to the main hospital building. The chapel was designed by Henry Hill of San Francisco; William Bernbrock was supervising architect. Glass-in-concrete panels and connecting links of stained glass were designed by Glassart.

The design of the chapel is triangular, with an alcove in each side of the triangle. One alcove forms the entrance to the chapel. In the other two alcoves, walnut seats with red cushions provide a resting place. The concrete panels in these alcoves are finished in oxidized gold. In the corners of the triangle, colored glass-in-concrete allows light to come into the chapel. Here patients can come for semiprivate meditation if they wish.

Except for a triangle of exposed

aggregate directly in the center of the structure, the floor of the chapel is Danish cork. In this center triangle, a clear glass bowl 5 feet in diameter stands on a bronze pedestal. In the body of the bowl, which is filled with constantly moving water, is embedded an atomic energy model (38 million electron volts). The bowl is illuminated by the rose glass "lantern" at the apex of the chapel. ■

(RIGHT) In two alcoves of the chapel are built-in walnut seats with red upholstery to accommodate ambulant patients and visitors. The three glass-in-concrete corners serve as semiprivate areas, either for sitting alcoves, or for bed patients should they wish to use this space. (BELOW) Webbed, precast steel-reinforced concrete panels in the form of trapezoids and triangles form the structure of the chapel. This view at dusk shows one side of the triangular structure and the passageway to the main hospital building. (BELOW, RIGHT) This view of the chapel is from the exact center, looking up at the glass "lantern". Concrete panels are left natural texture with a sand blasted finish.



PLANNING THE PATIENT SPACE

by ANTHONY J. J. ROURKE, M.D.

The planning of the patient space is one area of hospital construction that requires the closest attention of the hospital planning team if maximum patient comfort and operational efficiency are to be achieved, the author states. He singles out some of the areas of patient room planning in which decisions need to be made, giving alternate solutions and arguments for and against each solution.

HOSPITAL consultants, architects and engineers work daily in the areas of planning, but their administrator and trustee clients often are having their first experiences in planning new hospital structures. These administrators and trustees deserve the opportunity to make their own decisions, but they also deserve to have the areas that need their decisions identified, with possible solutions and a list of the pros and cons in each solution. Failure of the client to express an opinion regarding a single item in hospital planning, from either oversight or lack of knowledge, does not relieve the employed consultants, architects and engineers of their responsibilities for putting such items on the agenda.

Much of our hospital building has become stereotyped, repeating the same plan over and over. One area of hospital planning, the patient space, is in need of some new ideas that will promote more efficient care and greater patient comfort.

This article is directed, therefore, to those whose daily lives are spent in the functional areas of hospital operation in the hope that it will offer some useful suggestions for planning the patient space.

ROOM SHAPES AND CAPACITIES

The number of patients to be hospitalized in one room has undergone considerable change since World War II and the widespread coverage of prepayment care. The period of the large ward, accommodating 10 to 20 patients, is apparently gone. Trends would indicate that most of the recent building has utilized plans for single, two-bed and four-bed rooms.

As the large ward has given way to smaller units, the problems of placing windows, closets, lavatories and doors have assumed new importance. The sizes and shapes of rooms have also added to the need for study. The new pattern of a toilet with each patient space, as well as the internal arrangement of the toilet room, has challenged planners to bring these new comforts to hospitalized patients without squandering square footage.

There are many possible combinations for unit arrangements. Figures 1 and 2 (p. 50) show arrangements for one-, two-, three-, four-, five- and six-bed units.

Figure 1, Rooms 1 and 5, show two four-bed units, with toilet space on the corridor wall. In Room 1, the beds are placed head to head, with a partial wall separating them. This room requires more length, because space at the foot of the beds in each section will need to be wide enough for wheeled stretchers to pass. In Room 5, space in the center between the beds can be used to serve all four beds, but the necessary length of the room is less than that in Room 1 or the combined length of two double rooms such as Room 3.

Room 4 is identical in area to Room 5, but the space opposite the toilet room is utilized for a fifth bed.

DOUBLE ROOMS

Rooms 2 and 3 are identical double rooms with toilet space on the wall, but Room 2 has the heads of the beds on opposite walls while Room 3 has them against the same wall. Proponents of the Room 2 arrangement believe that each patient has a better view through the window, and that they are in a better position for conversation with each other.

Those who do not favor the "opposite wall" approach of Room 2 believe that the room appears untidy; and that it is undesirable to have the bed adjacent to the window wall in full view from the corridor when the door is open.

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This article was adapted from a presentation at the 62nd Annual Meeting of the American Hospital Association, Aug. 30, 1960, San Francisco.

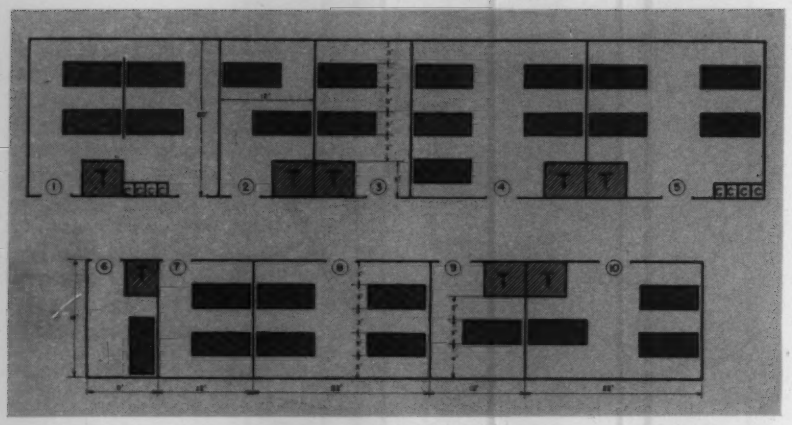


Fig. 1—Room shapes and bed capacities

They believe that some minor problems occur with cubicle tracks and curtains in this arrangement, and that costs are increased because service lines (nurses' call, night lights, bed lights, telephone, television, radio, etc.) can serve only two beds in rooms such as Room 2, while they serve four beds in rooms similar to Room 3.

POTENTIAL CAPACITY

Rooms 1 through 5 show possible arrangements and potential capacity when toilet rooms are placed on the corridor wall. Such rooms should be planned to allow 3 feet between the window wall and the nearest bed, 3 feet between beds, 3 feet for each bed and 3 feet between the toilet room wall and the nearest bed. Thus, 15 feet in the clear is the minimum width for such two-bed rooms. To allow for movement of stretchers around the foot of the first bed to reach the second, a minimum length of 12 feet should be allowed and no dresser should be used (see Figure 1, Room 3 for net dimensions).

Rooms 6 through 10 show one-, two-, three- and four-bed rooms in which the depth of the room is 15 feet, rather than the 20 feet shown in Rooms 1 through 5.

Room 6 shows the small single room with toilet, using a corner bed rather than the island bed. Those in favor of this small single room say that the privacy afforded the patient outweighs all disadvantages, the corner bed (against the wall) allows for economy of square footage and the need to move the bed poses no problem. Those opposed to this arrangement say that the room is inflexible and may never be doubled in any emergency (the proponents feel this to be a major virtue), that the bed must be moved for patient care and bed making and that the position of the patient requires him to crane his neck to look out the window, which must be on the wall back of the head of the bed.

Rooms 7 and 8 show a two- and four-bed room, without toilet rooms which requires the use of a central toilet. Most hospital consultants knowing the increased demands on nursing time, strongly recommend that toilet rooms be provided within all patient rooms (both single and multiple).

Room 9, which is 12 feet long as compared with Room 6 which is 9 feet long, allows for a single room with an island bed and a toilet room. Room 9 can be expanded as in Room 10 by increasing its length to 22 feet in the clear to provide for three beds, still retaining the 15-foot depth.

Rooms 1 and 2 in Figure 2, p. 50, show a three- and a six-bed room, each having a 21-foot depth in the clear for the heads of the beds and 12- and 22-foot lengths, respectively.

Rooms 3 and 4 show a depth of only 9 feet and are without toilet rooms. Toilets could be centrally located or could be placed between the rooms.

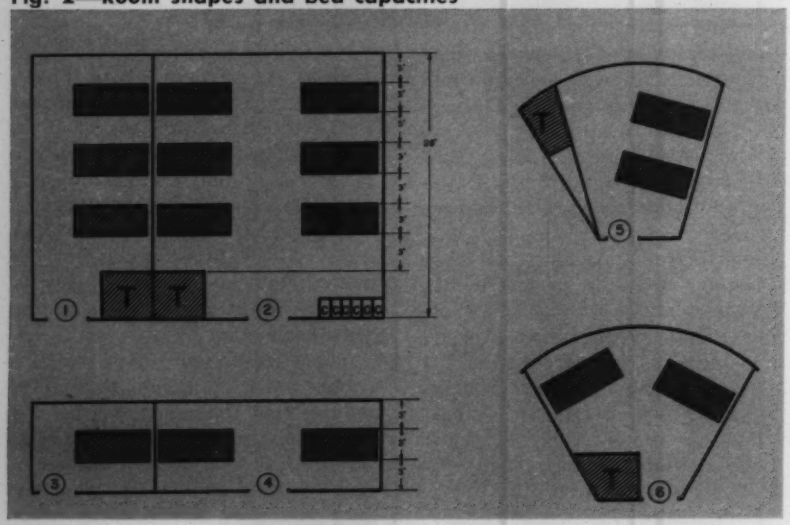
EFFICIENT SPACE USE

These two sets of rooms show two extremes in making the most or the least use of corridor and periphery length per bed. Combining Rooms 1 and 2, there are nine beds for 34 feet of corridor and 34 feet of peripheral wall, or an average of approximately one bed per 3.8 running feet of corridor and the same for peripheral wall space.

In contrast, Rooms 3 and 4 combined show only three beds for the same length of corridor, and an average of one bed per 11.3 running feet of each wall. The scheme used in Rooms 3 and 4 would greatly reduce the number of beds possible in each nursing unit. It would require more floors and more corridor runs to furnish a given number of beds than would a scheme in which the two- or three-bed deep plan is used.

Those in favor of the plan shown in Rooms 3 and 4 of Figure 2 believe that being near the window

Fig. 2—Room shapes and bed capacities



is important and outweighs the disadvantages.

Those who do not favor the plan believe that with the shorter stay and early ambulation, being near the window is not a major factor. They contend that if one accepts the limit of 90 feet from nursing station to the most distant bed, the possible number of beds per nursing unit is so reduced that an optimum size unit cannot be achieved in an acceptable shape. They also hold that since corridor and peripheral wall space represent sizable investments, the greatly reduced number of beds makes the plan too costly.

PIE-SHAPED ROOM

Rooms 5 and 6 in Figure 2 are shown as reminders of the pie-shaped room of the circular hospital. The round hospital, as of today, is one of the five most debated subjects among planners. Whether it is an "attention getting device" or a real advance remains to be seen. Too little experience has been accumulated upon which to judge. Many consultants feel that it has little to offer and that the problems it creates are not offset by advantages. It is the intention in this paper to mention Rooms 5 and 6 only as an indication that this shape is highly experimental and to urge every hospital desiring to follow such a plan to do so with the full knowledge that it is becoming part of an experiment with a yet unproven plan.

TOILET ROOM LOCATIONS

Figure 3, p. 53, shows six double rooms (1 through 6) with toilet rooms on the corridor wall and, across the corridor, six double rooms (7 through 12) with toilet rooms between.

Exclusive of walls, Rooms 1 through 6, including toilet rooms, occupy about 1440 net square feet, or 120 square feet per bed. On the same basis, Rooms 7 through 12 occupy, with the three intervening toilet rooms, about 1237 net square feet, or about 103 square feet per bed. It would appear that there is a difference of about 17 net square feet per bed, but this is only part of the story. In the plan of Rooms 7 through 12, there are 10½ more lineal feet of corridor and 10½ more lineal feet of periphery wall than for the same number of beds in the plan of Rooms 1 through 6. In addition, more steps will be required to get from the nursing station (n.s.) to Room 12 than to Room 6, to Room 11 than to Room 5, and to Room 9 than to Room 3.

The plan of Rooms 7 through 12 does not give protection from corridor view to the patient in the first bed, as does the plan of Rooms 1 through 6.

BATHROOM LOCATION

Planning toilet and lavatory facilities back-to-back is an economical approach (see Figure 4 p. 53). Rooms 1 and 2 show two double rooms with such a back-to-back toilet room plan along the corridor wall. This is the plan most often used.

Rooms 3 and 4 use the same back-to-back plan but place the toilet rooms on the window or peripheral wall. Proponents of this plan believe that a window in the toilet room is desirable, and that the space outside the bathroom door may be used as sitting-room space. Those not favorable to this plan hold that (1) mechanical ventilation is more dependable, (2) some of the outside view is obstructed by the toilet room, (3) additional steps must be taken by the nurse both to get equipment and for handwashing after patient contact, and (4) bed arrangement is less satisfactory.

Rooms 5 and 6 in Figure 4 show single rooms with toilet and shower rooms on the corridor wall. It is likely that there will be more and more demand for patient rooms with showers in future hospital construction.

Rooms 7 and 8 show toilet rooms situated between patient rooms.

Rooms 9 and 10 show a shared toilet room placed between two double rooms. Such a toilet may be placed on the corridor or window-wall side. The proponents of this scheme believe that it saves capital funds by reducing the number of toilets from one for every two beds to one for every four beds. Those who do not favor the shared toilet room contend that it results in inflexible availability of the adjoining rooms (such as 9 and 10) for male or female patients, and it causes much inconvenience when the patient fails to release the lock of the opposite door when he leaves the room.

Rooms 11 and 12 in Figure 4 show the shared toilet room with the addition of a bath. The same pros and cons apply here as in Rooms 9 and 10.

In Rooms 9, 10, 11 and 12 lavatories are placed in the patient space.

LOCATION OF CLOSETS

Shortened hospital stay and better transportation that allows for frequent visiting has changed the need for bringing large amounts of apparel at admission. The plan of returning as much as possible to the patient's home has further reduced the need for large closets. Figure 5, p. 53, shows location of closet space in the patient's room.

Room 1 shows closets in opposite corners on the back wall. This reduces free space on the back wall, crowds work space, and to some extent, disturbs a sick patient as the nurse or aide works at the closet.

Room 2 places closets on the wall opposite the beds. This breaks up this wall, reduces possibilities of decoration and reduces the space for chairs or for turning stretchers.

Rooms 3 and 4 incorporate closets in the dividing wall, with two closets opening into each room. Again the patient is forced to look at closet doors continuously. This arrangement also makes decorating difficult, blocks sitting space in one room where the closet meets the window wall and gives an untidy appearance when doors are open.

Rooms 5 and 6 place closets on window wall and corridor wall, with the dividing wall at an angle from opposite sides of the closets.

Rooms 7 and 8 incorporate closets in the dividing wall opposite the toilet room doors. This does interfere somewhat with the door to the corridor but allows the wall opposite the beds to remain clear for decoration, electrical outlets and for chairs.

Rooms 9 and 10 place a pair of closets on the toilet room wall in two different ways.

Room 11 reduces the width and increases the depth of the toilet room to allow for closets on the corridor wall outside the toilet

room door. This reduces the desirable 15 feet in the clear from toilet room wall to window wall. The arrangement in Room 12 may disturb the patient in the adjacent bed as closets are used.

Many planners believe that, wherever possible, closets should be kept out of that space considered to be the bed room, that is the 15 by 12-foot area in the double rooms as shown in Figure 5. Keeping the closets somewhere in the alcove formed by the toilet room, corridor door and the dividing wall to the next room seem to receive the greatest approval. This can be a crowded area, but it seems that the disadvantage of crowding is more than offset by the uncluttered appearance of the room and the availability of the entire bed area for circulation and equipment.

LAVATORY LOCATION

The location of the lavatory is seen in Figure 6, p. 53. Plumbing costs often dictate the best location, especially when toilet rooms are back-to-back. Rooms 1 and 10 show the lavatory within the toilet room; Rooms 2, 3, 5 and 6 suggest locations for lavatory when it is situated outside the toilet room; Rooms 4, 7, 8 and 9 suggest a lavatory within the toilet room as well as one in the bed space.

Hospital planners advocating one lavatory per patient space placed in the bed space rather than in the toilet room favor the arrangement on the grounds that if the toilet room is occupied, the other patient has access to the lavatory, and that a lavatory in the patient space encourages doctors and nurses to carry out handwashing between patients. Planners who favor one lavatory per patient space situated in the toilet room believe that without a lavatory in the toilet room, it is impossible to carry out personal hygiene and the door knob becomes highly contaminated. Also, they point out, local perineal bathing, which may be necessary several times a day, will not be done behind a cubicle curtain in the patient space but needs the psychological security of a locked door in the toilet room.

If a lavatory is considered essential in the patients' room, a second lavatory in the toilet room should be added for hygienic and psychological reasons. However, this adds to capital expenditure.

LOCATION OF BEDSIDE STAND

Location of the bedside stand is important both to patients and nurses. In a semiprivate room, mounting both bedside stands on a single base and placing the unit between the beds held some promise when this method was first devised, but it has been proven to have some drawbacks. It interferes with the cubicle curtains, for one thing. Also, although this arrangement places the nurse in a position with her right hand toward the patient and her left hand toward the equipment on the stand while caring for the patient in one bed (the desirable position for right-handed personnel), when the nurse turns to care for the patient in the other bed, her position is reversed —an awkward position if she is right-handed. Many nurses believe that each bedside stand should be separate and placed at the right of the patient when he is in bed. Such positioning also solves the cubicle curtain problem.

SWING OF CORRIDOR DOOR

Sometimes the placing of closets or the location of the toilet room door tempts builders to hang doors so that they swing away from the toilet room. This allows for almost direct vision of the beds from the corridor. Although this arrangement allows nurses to see patients from the corridor, it is undesirable to have the patients in view of all visitors.

If the door is swung toward the toilet room, it may be left ajar without allowing observation of the beds from the corridor.

TOILET ROOM DOOR

Doors that swing into the toilet room present a problem if the patient faints against the door. It is simple to obtain hardware that will release the lock from the outside, but it is another story to push the door open against an unconscious patient. Emergency access to the toilet room can be provided by using an inset in the door that will open out, or by having a removable panel elsewhere in the toilet door. However, both are expensive measures.

Opening the toilet room door out avoids the danger of hitting the unconscious patient behind the door but results in the constant nuisance of conflicting doors, or the undesirable opening of the door against the bed. Roller bumpers may help.

There is a new type of hardware that allows the door to open into the bathroom under normal circumstances, but in an emergency allows it to swing out into the room.

When considering door swing, planners should remember that they are dealing with sick and perhaps aged persons who may be under medication, and that all possible psychological protection should be built in. The door opening and exposing the toilet should be avoided in favor of a plan which does not allow direct vision of the toilet.

WINDOW SIZE AND LOCATION

The size, location and type of window pose difficult questions. This paper will not try to outline any answers, but a few pointers may help the planning team in making decisions regarding windows:

1. Sick people are often more sensitive to light than those who are well.
2. Window planning for a hospital should not be governed by good rules for hotel or office building planning.
3. Glass is a conductor of heat and presence or absence of air-conditioning and extremes of climate may govern the amount used.
4. Glass may be insulated to prevent the thermal effects of weather changes on the room, but such a procedure is costly.
5. The amount of glass will have a direct bearing on the costs of window washing.
6. A continuous band of glass from wall to wall will eventually be covered with a venetian blind or a set of drapes. Diffused light may be pleasant, but drapes and blinds are costly to install, maintain and clean.
7. Some planners believe that a solid wall punctured with one window leads to more glare because of the sharp contrast from bright light to the dark space around the window.

8. If windows are opened for ventilation, their positioning and type should be constructed for maximum patient comfort by reducing direct draft.

9. Windows reaching to the floor may cause the fear of falling. They also permit a view from the outside of the underside of beds and drainage bottles (one-way glass may stop this).

10. Windows are an architect's tool for creating beauty in the exterior of a building. This function of windows should not be ignored if it does not create problems in patient care.

11. The size of the windows may depend upon the desirability of the view.

Using a single window may have several advantages over using multiple window arrangements:

1. The patient on the window side may face the wall without looking directly into the sunlight.

2. Vision across the foot of the window-side bed is much better than across the head.

3. A patient sitting in the corner formed at the foot of the bed by the window wall and the dividing wall may enjoy the view by direct observation.

4. When the door is open, daylight will come across the room into the corridor.

5. If the window is opened, the possibility of drafts on the patient in bed is reduced.

ILLUMINATION

One area that needs detailed discussion with the hospital building committee and the administrator is the matter of patient space illumination.

The desirability, type and location of the following should be explored: ceiling light, bed light, night light, chair reading light, portable light, surgical dressing cart light, extension cord light and toilet room light.

OTHER CONSIDERATIONS

Bed Pan Flushers. Traditional back-to-back arrangement of toilet rooms to take advantage of supply and waste lines frequently results in an inconvenient location of the bed pan hose; that is, it is to the right of the toilet in one of the rooms and to the left in the other.

(Continued on page 129)

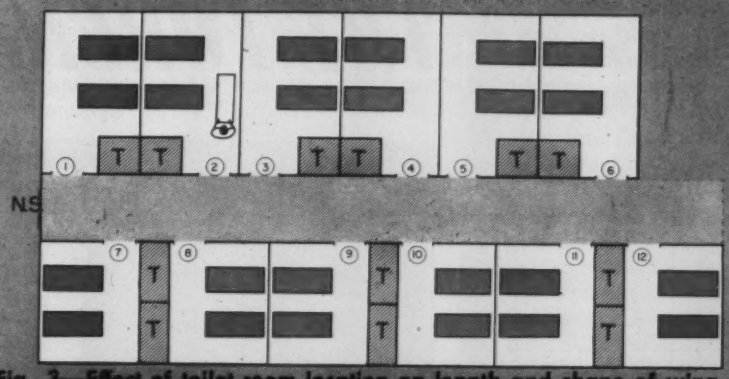


Fig. 3—Effect of toilet room location on length and shape of wing

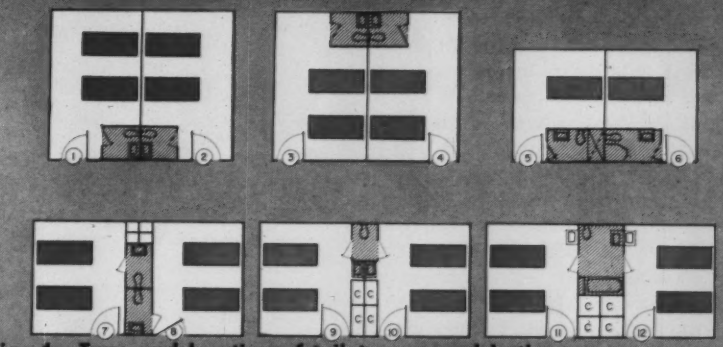


Fig. 4—Type and location of toilet room and bath

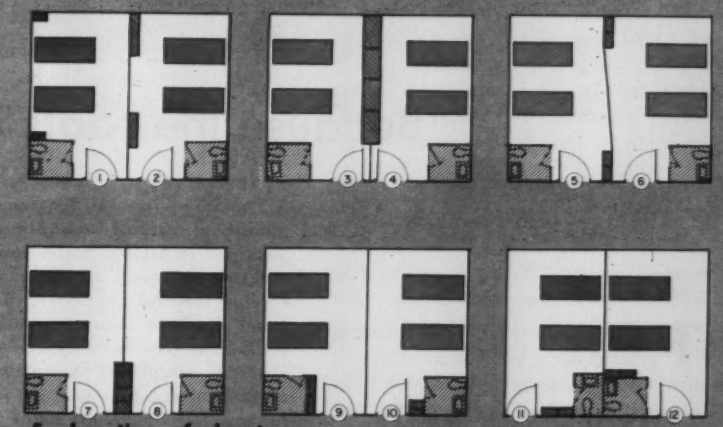


Fig. 5—Location of closets

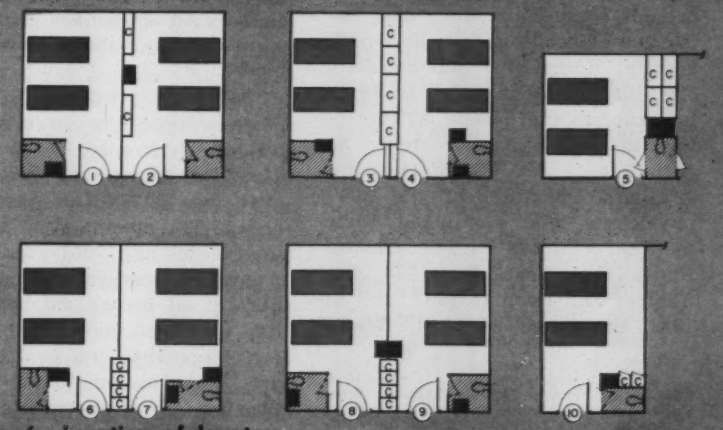


Fig. 6—Location of lavatory

THE FOREIGN GRADUATE

Because the roots are deep, the remedy

by WILLARD C. RAPPLEYE, M.D.

The major reason for the growing number of unfilled hospital house staff positions in United States hospitals is not the reduction in the number of foreign medical graduates, the author states. Far too many internships and residencies have been approved for the available supply of American graduates. The situation can be remedied, he suggests, by modification of existing graduate training programs and employment of qualified graduates on a full-time or part-time basis in hospitals.

THE PROBLEM of foreign medical graduates is only one phase of the whole postwar program of hospital and medical services for the country. In the background of the present situation is the rapid expansion of positions in "approved" hospital internships and residencies during recent years. In 1920, for example, there were 3420 openings in internships recognized as satisfactory for the continuing graduate education of the 3047 physicians who completed their medical courses in the United States that year. By 1930, the number had risen to 5531, and in 1941, the figure was 8182. Many of these programs were for periods of 18 months or two years. The total of medical graduates in 1941 was 5275. This year, there are 13,032 openings in approved internships and 7081 graduates of American medical schools. The number of recognized internships has increased more than 50 per cent since 1941, but practically all are now limited to 12 months, because of requirements of the armed forces and Selective Service. This change in the length of many internships is a factor in the present number of unfilled hospital positions.

Openings in approved residencies in 1940 numbered 5256, or double the total of a decade before, and 8930 in 1945. Following the war, the number jumped to 17,293 in 1948 and to 31,733 in 1960, or an increase of nearly 600 per cent in two decades. Graduates of foreign medical schools occupy 6042 of those appointments at present. This rapid growth is explained largely by the postwar expansion of residency programs for the benefit of returning servicemen. These programs temporarily called for a great increase in postgraduate and refresher training opportunities, many of which were continued after the immediate needs were met; by the increased demands for more adequate hospital care of patients, and the more complete coverage of night and week-end services; by the sudden

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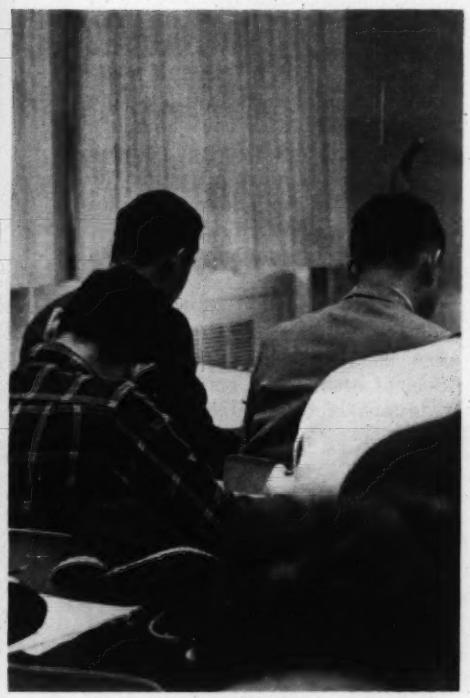
PROBLEM



will not be swift

pressure for advanced training in many clinical specialties to meet changing conditions of medical practice; by the phenomenal advances in medical and surgical procedures of all kinds, and by the requirements of the specialty boards. Under the circumstances, many residencies were created and approved which did not provide or continue real educational opportunities once established.

The facts cited indicate the great spread between the number of graduates from American schools and the hospital positions approved for educational purposes by the Council on Medical Education and Hospitals of the American Medical Association. The gap has led to a widely held opinion that the medical schools should graduate enough physicians to fill all the hospital positions. It is not the purpose of medical schools to produce enough graduates each year to do this, nor is there really need to do it. Far more residencies and internships have been approved than should have been. Many residencies and internships now are intended and designed more as service functions for the staff and hospital than for educational purposes. In the State of New York, for example, an intern does not legally have to possess a medical degree. The purposes of the internship and residency are primarily educational, not primarily for hospital services, although the care of the patients is an obligation of the house officers under supervision of the attending physicians and medical board.

ILL TRAINED PHYSICIANS

Since there are approximately 7000 hospitals in the country and only 1300 have approved educational programs at the present time, it is easy to see what might happen if the medical schools were expected to fill all the hospital house staffs and produce a large surplus of ill trained doctors, assuming that the schools could get enough qualified students and adequate staffs to educate them. At the present time there are not enough qualified medical students to fill the medical schools. The plain fact of the matter is that in this particular situation there are too many positions in approved internships and residencies—not too few medical graduates.

Public Law No. 293, passed by Congress in 1946, enables the Veterans Administration to inaugurate internship and residency training programs in its hospitals in collaboration with the medical schools through local deans' committees. Eleven per cent of all approved residencies in the country are now in these hospitals alone. Other federal agencies have also expanded greatly the opportunities for advanced training. There are now more than 3720 residency positions in the federal hospitals.

The number of graduates of medical schools has increased slowly during the postwar period, while the total of approved residencies has risen approximately 600 per cent. The result has been a rapidly growing gap between the number of approved residencies and internships and the available supply of American graduates. This explains the many unfilled hospital house staff positions.

In 1948, Congress passed the United States Information and Educational Exchange Act, effective July 1, 1949. This law facilitates the obtaining of visas for "educational purposes" for foreign students from most areas of the world, but it does not set up any educational standards for admission to the country. The creation of the vacuum mentioned above and the action by the federal government in encouraging graduates of foreign medical schools to come to this country explain many of the present difficulties. The open invitation to medical graduates from all over the world to come to the United States regardless of the level of their professional preparation has precipitated a situation with little or no forward planning to provide the educational opportunities that many of these men and women from those countries had expected would be available.

The report of the Advisory Committee on Internships of the Council on Medical Education and Hospitals of the AMA published in 1953, pointed to many of the defects and inadequacies that exist in internship and residency training.* Translating some of the recommendations into enforceable conditions for approval of internships and residencies would be an important step forward. The overall problem can be solved only if the accrediting agencies assume real responsibility for proper educational standards for internships and residencies.

QUALIFICATIONS OF GRADUATES

One serious error has been the assumption that many of the foreigners could be fitted immediately into American hospital programs. It is a fact that some of these foreign graduates, particularly those coming from the recognized schools in Europe, or approximately 28 per cent of the foreign graduates in this country now, have had opportunities for advanced training in teaching institutions and are well prepared. This interchange of graduates between American and foreign teaching centers has been a long established and highly valuable

*J.A.M.A. 151:499 Feb. 7, 1953.

program and needs to be expanded. The largest proportion of the foreign graduates who have entered the country in recent years, however, has come from areas and institutions which have not been able to provide an adequate general education, proper preparation in the basic sciences or any form of active clinical experience with patients. Often graduates are from "medical schools" that have excessive enrollments, almost entirely didactic instruction and practically no supervised training in laboratories or hospitals.

For the most part, the inadequately trained foreign physicians have gone to the hospitals which have not been able to attract graduates of the American and Canadian medical schools. It is unfortunate that this country is put in the apparent position of depending to a considerable degree on physicians from foreign countries to maintain its community and nonuniversity hospitals when most of the countries from which the foreign graduates come are acutely short of physicians. This is being done under the guise of offering "educational opportunities" in institutions whose primary concern is to find help to provide routine hospital services for patients and attending staffs. It is probably true that many of the foreign medical graduates are coming to the United States for other than educational reasons. This is reflected in the fact that many of those who have failed the September 1960 examinations of the Educational Council for Foreign Medical Graduates (ECFMG) are now applying to hospitals whose "residencies" are not approved.

However, hospitals with unapproved internships and residencies who employ uncertified foreign medical graduates place their listing by the American Hospital Association in jeopardy, because listing by the AHA is a prerequisite to accreditation by the Joint Commission on Accreditation of Hospitals (JCAH). Their accreditation status, if the hospital is accredited, would be in peril.

NUMBER OF STUDENTS

There are approximately 12,000 graduates of foreign medical schools from 91 countries in the house staff positions in this country (roughly 33 per cent of the total). Three per cent of these are U.S. citizens who have studied abroad, particularly in Italy and Switzerland. Approximately 10 per cent are aliens with immigrant visas and the balance (approximately 20 per cent) are on exchange visitor or student visas. Roughly 27 per cent of the number in the United States are in New York State. Approximately 48 per cent of all the house staffs in New York City are graduates of foreign medical schools. The largest numbers come from the Philippines, Mexico, Turkey, Korea, Greece, Japan and India.

Many of the foreign physicians are excellent individuals with good personal and intellectual qualifications but most of them from other than certain European schools have had no opportunity in their native lands to acquire a professional education that could be regarded as satisfactory. In many sections of the country, there are now two classes of citizens as far as house staff services are concerned: those whose medical care is provided for by physicians who have had a satisfactory preparation for medical practice and those whose medical care is provided by physicians who have had a medical education below the standards accepted as adequate.

SCREENING PROGRAMS

Many different screening procedures have been set up in different states in an attempt to evaluate the qualifications of the physicians coming from abroad. A number of institutions have established postgraduate lecture and tutoring courses and other devices to help the foreign graduates on the house staff to take care of patients and to obtain clinical experience. Many of the foreigners are handicapped by language difficulties and lack of information about the traditions and methods of American medicine, as well as a lack of satisfactory grounding in the medical and clinical sciences.

In an attempt to help meet this over-all situation and to protect the American public and the hospitals which serve it, a number of the screening programs have been brought together in a joint effort under the ECFMG. This is a national organization supported by the AMA, the Association of American Medical Colleges, the AHA, the Specialty Boards, the JCAH, the Federation of State Board of Medical Examiners and several of the federal agencies. The council's primary objective was stated "to promote opportunities in the United States for advance studies in medicine so that the level of medical care throughout the world might be raised". Elsewhere, the statement is made that the function is "to determine that the foreign medical graduates reach a level of attainment comparable to graduates of the United States and Canadian schools". This is largely wishful thinking and an unattainable hope in many instances.

In another statement, the ECFMG states its attempt to ensure that "approved U.S. hospitals will be getting graduates of 'bona fide' medical schools with a satisfactory command of English and a comprehensive knowledge of clinical medicine".* Some of the so-called 'bona fide' foreign medical schools are reminiscent of the former diploma mills of 40 years ago in this country.

PROCEDURES FOR SCREENING

As a practical procedure, the ECFMG must rely almost entirely upon a written examination using the multiple choice question. This device can never be fully adequate for the evaluation of the qualifications of an individual, especially in medicine. The use of this type of examination is a handicap to those unfamiliar with its structure. At best, any written test is only a partial method of selection. Under present circumstances, the program of the ECFMG—in spite of its inadequacy and difficulties—is an earnest effort to help solve the problem of the foreign medical graduate.

One of the regulations of the Council on Medical Education and Hospitals of the AMA is that regardless of the date of appointment, it is expected that all graduates of foreign medical schools serving as interns or residents in

*ECFMG Annual Report for 1959.

approved U.S. hospitals as of July 1, 1960, would have been certified by the ECFMG. The effective date of the implementation has been extended under certain circumstances through June 30, 1961, in order to provide another opportunity for the ECFMG examinations of those who have failed the September 1960 test or have not taken it.

On Nov. 18, 1960, the Board of Trustees of the AHA reaffirmed its support of the ECFMG, pointing out that after the established deadline, the Association would not list any hospital or renew the listing of any hospital having on its staff in a patient care situation any graduate of a foreign medical school who did not have a full and unrestricted state license to practice or who had not been permanently or temporarily certified by the ECFMG.

It has been predicted that some hospitals, public authorities, medical boards and others unable to obtain graduates of approved medical schools would object to the plans of the ECFMG and its cooperating agencies. The U.S. State Department, which has issued student or visitor visas to the foreign medical graduates, is now concerned with the problem because of possible political and international implications in the enforcement of even the minimal standards of an examination.

RESULTS OF EXAMINATIONS

Approximately 8713 foreign

HOW HOSPITALS ARE MEETING THE PROBLEM

Taking advantage of the time between Dec. 31, 1960—the deadline for removing uncertified or unlicensed graduates of foreign medical schools from patient care situations in United States hospitals—and April 4, 1961—the date of the next examination offered by the Educational Council for Foreign Medical Graduates (ECFMG)—several hospitals, one state health department, one hospital council and one state department of mental health, have launched training programs aimed at helping foreign-trained house officers to pass the April 4 ECFMG examination.

Gov. Nelson A. Rockefeller of New York in a letter to Frank S. Groner, president of the American Hospital Association, stated: "The basic problem of providing an adequate supply of well trained physicians must be attacked throughout the country if we are to prevent future crises. In New York State, we are planning to take steps this year (1961) toward that end."

At a meeting in New York City on Dec. 29, 1960, attended by representatives of interested hospital and medical organizations, both local and national, Governor Rockefeller offered immediate assistance from the state to establish intensive training programs for noncertified foreign medical graduates.

Fifteen hospitals belonging to the Greater Cincinnati Hospital Council cooperated in establishing an intensive program for their foreign-trained house officers who plan to take the April 4 ECFMG examination. The Cincinnati program, which will extend over three months, is voluntary; no foreign-trained house officers are required to attend. For those who do attend, the ad hoc committee which set up the program will recommend how much work in medical areas or in the field of English any participant should take.

Instead of developing a special program for noncertified foreign medical graduates, the Cincinnati group has prepared a series of conferences, demonstration and teaching sessions that will provide broad coverage of participants' needs. The Cincinnati program also includes instruction in English, taught by board of education specialists.

Individual hospitals are organizing programs too. In Brooklyn, one hospital is providing an intensive training program for house officers preparing for the April 4 ECFMG test, which consists of lectures, demonstrations, laboratory sessions, departmental conferences and staff meetings. House officer attendance at these is compulsory.

The content of the course covers basic sciences, such as anatomy and physiology; surgical emergencies, such as ruptured gall bladder; obstetrics; pediatrics; classification and etiology of diseases, and fluid and electrolyte balance. This program began Jan. 3, 1961, and will conclude April 6, 1961.

The Hospital Council of Maryland, Inc., in cooperation with 16 hospitals and the State Department of Mental Hygiene, is preparing a "Community Medical Education Program for Foreign Medical Graduates". The sessions were expected to begin early in January.

Madison B. Brown, M.D., associate director of the American Hospital Association, and director of the Department of Professional Services, has suggested that hospitals preparing or administering such intensive training programs for their foreign-trained house officers should stress the basic aspects of medical education, such as physiology, anatomy, chemistry, etc., because these are the areas in which foreign graduates are most deficient. ■

medical school graduates took the examinations held on Sept. 21, 1960, and 71 per cent received either the standard certificate or the temporary (two-year) certificate. The large number who passed the tests indicates how ineffective any system of examination alone is in evaluating the educational preparation of a physician since most of the foreign graduates have not obtained a real medical education. The present methods of dealing with this entire problem are not serving the best interests of those foreign medical school graduates, their own countries, the American hospitals, or good international policy. There is urgent need of a long-term, imaginative approach to this phase of America's contributions to the needs of underdeveloped countries.

Public Law No. 555, enacted by the 84th Congress and approved on June 4, 1956, may help to ensure that foreign physicians trained in hospitals in the United States will return, after the completion of their training, to their home countries. This amendment to the U.S. Information and Educational Exchange Act of 1948 restricts a citizen of a foreign country who is here under the exchange visitors program, a classification which includes many foreign interns and residents, from being granted an immigrant visa or an adjustment of status to that of a permanent resident in this country or for a nonimmigrant visa, "until it is established that such a person has resided and been physically present in a cooperating country or countries for an aggregate of at least two years following departure from the United States".

EDUCATIONAL PROGRAMS

The House of Delegates of the AMA in December 1960 adopted a report which included the following statement:

"In order that those foreign physicians who have not yet been certified by the Educational Council for Foreign Medical Graduates might be given further opportunity to enhance their medical education, hospitals would be encouraged to develop special educational programs. Such programs must be of educational worth to the foreign graduate and must divorce him from any responsibility for patient care. Foreign physicians may participate in these programs until June 30, 1961, with approval of the Department of State so that their exchange visa will not be withdrawn before that time. This will also allow the noncertified foreign physician the opportunity to take the April 1961 Educational Council for Foreign Medical Graduates examination." These plans were developed in cooperation with the State Department and the American Hospital Association and have their concurrence.

A number of plans have been proposed offering intensive programs for the qualified foreign medical graduate to study and to become proficient in English, particularly spoken English, so essential for communication with patients and families. These suggestions call for a period of a year or more of preinternship and preresidency preparation in order to allow the foreign graduate to take advantage of his hospital experience. These ideas have not been developed widely, because the medical schools are already overloaded with their own responsibilities for American students, and funds are not available to develop any large-scale programs of this character in good community hospitals. It is evident that in fairness to all concerned, the screening procedures for the foreign medical graduates should precede their arrival in this country.

ASSISTING UNDERDEVELOPED AREAS

Most of the proposals are aimed at meeting a temporary situation, but inherent in the whole problem is the long-term challenge to this country of assisting the underdeveloped areas of the world largely through strengthening the scientific, educational and medical efforts in those sections of the globe that do not possess the facilities, trained personnel and leadership which are so well developed in this country and in free Europe.

A number of medical schools have made an excellent start in this direction during the last 5 or 10 years through offering opportunities in the teaching centers here for well qualified foreign medical graduates and scientists with the understanding that these individuals would return to their native lands to help create and to develop modern programs of medical education there. Several of the leading foundations have been doing this for a number of years with most promising results. The U.S. Department of State on April 24, 1959, set a limit of five years on the stay of foreign medical graduates serving internships and residencies in this country as an expression of the intention of Congress that the exchange visitor "should return to his homeland". It is obvious that this is a slow and long-term program.

HOSPITAL ATTENDING STAFFS

A feature of the foreign medical graduate problem that is often overlooked is that the employment of such personnel does not in the long run help the recruitment of the future attending staffs for the hospitals. Many of the foreign graduates are now expected to return to their homelands and hence will not be available, even if qualified, for replacement and the building up of the attending positions. The problem of the attending staff is acute, because of the migration of many recent U.S. graduates to the suburbs and small communities where facilities and opportunities for practice are excellent and because of the increasing employment of qualified physicians by industry, public agencies, insurance companies and hospitals.

In the United States, the internship has come to be regarded universally as an essential part of the preparation of the physician. It is a requirement for licensure in many states. The residency plan has become the basis of true graduate medical education. To use these two important designations —generally accepted as a part of the educational pattern of American medicine—as a lure for the recruitment of untrained or incompetent individuals discredits the entire effort to maintain professional standards in this country.

Many suggestions have been made to help meet the situation caused by the reduction in foreign medical graduates in the intern-

ships and residencies under the regulations of the Council on Medical Education and Hospitals. One has been the institution of a two-year internship, which was common in the past. However, there is a growing disposition to telescope the internship and residency training as already in effect in some of the teaching institutions. Consideration is being given, or is already in operation in certain hospitals, to eliminate the internship altogether, because of the improvement in clinical clerkships and similar educational programs. The good internship, however, is an important step in the maturation of the young physician, for it represents the first period of responsibility for the actual care of patients, under the supervision of the attending staff.

Another suggestion has been that fourth-year medical students might be used to cover intern and residency duties. This plan, however, where tried has not been satisfactory as predicted, because it confuses the educational opportunities of the undergraduate medical student with hospital duties and responsibilities at the crucial stage of his professional life. It would be a poor expedient.

SUPPLEMENTARY MEASURES

In a number of institutions, the medical board and attending staff have assumed a system of rotation during the emergency by having members remain on call for the entire hospital on week-ends and nights. This is a sharing of responsibility by the attending staff and the medical board for the care of the patients in the hospital during those periods not likely to be covered otherwise. Directors of medical education are in existence now in many community hospitals which help to meet the training needs of the house staffs. This device is often only an intermediate step in the proper organization and functioning of the attending staff itself, which ultimately must satisfy the obligations of the approved hospital for education as well as patient care.

A new device being developed also holds promise—that of an affiliation between voluntary and municipal hospitals. These affiliations may also be worked out, as they have been with the teaching hospitals or university centers, greatly to the advantage of the staff, the resident, the patient and the public. The current hardship situations do not appear to be insoluble if the medical board of each hospital studies and works out a plan of responsible and adequate coverage. The medical board, after all, is responsible for seeing that proper care of patients is assured.

New York City is going forward with a plan also to help strengthen the professional services required by present-day methods and supervision, particularly in the municipal hospitals not affiliated with medical schools. In substance, the plan is to supplement the services provided for many years by voluntary practitioners through the creation of a small nucleus of full-time, salaried directors of the major services in these institutions who will be responsible for the guidance and education of house staffs and the augmentation of the professional programs. This proposal has as its primary purposes the strengthening of the programs of patient care and the development of better teaching programs for interns and residents.

Some degree of assistance can be provided by the proper utilization in the laboratories, radiology services and other places of well trained technicians who can relieve the house staff of certain routine procedures. Surgeons can help by using other practicing physicians as assistants in operations.

It has been proposed that the teaching centers reduce the number of their interns and residents and thus make a larger number of recent graduates available for such appointments in community hospitals. However, the medical graduate will attempt, as he should, to obtain an opportunity for completion of his professional education where he believes he can obtain the best. Many community hospitals do offer excellent educational inducements and obtain house staffs.

A LOGICAL SOLUTION

The most logical solution to the over-all question of adequate staffing for American hospitals is probably the employment of well qualified recent graduates on a full-time or part-time basis by the hospitals. Such young physicians can remain in the positions for a period of several years while they themselves are getting established in the community. This in part would help fill the difficult period between the completion of residency training or military service and the start of practice. Studies indicate that a majority of present residents would under proper conditions welcome such opportunities. Approximately one-third of the recent graduates in private practice are in some form of "group" practice.

HIGH QUALITY MEDICAL CARE

Plans can only be worked out through and with the support of the medical boards which have primary responsibility for the professional care of patients and with the sympathetic understanding of the profession at large and the help of the medical schools, which, although heavily engaged in their own obligations, can be of great assistance. All of these agencies—the profession, the medical boards, the hospitals, the licensing bodies and the educational institutions—are dealing with a common problem of assuring the continuation of a high quality of medical care, the education and the proper preparation and utilization of the next generation of physicians and attending staffs and a dedication to the public interest.

The hospital is a vital part of the whole system of American medicine and a vehicle of great value in research efforts, the community application of new knowledge regarding health and disease preventing and in medical education. Fortunately, many of the community hospitals now have modern laboratory and other facilities and professional staffs of excellence and good training, some of them on a full-time basis, who would be able to offer a high quality of instruction to medical students, to house staffs and to local practicing physicians if given the opportunity and incentive under proper educational leadership and guidance. ■

HOW CHANGING PATTERNS OF PAYMENT AFFECT HOSPITAL PLANNING

by DEAN A. CLARK, M.D.

Hospitals can scarcely make realistic plans for the future without a keen awareness of changes in the mechanisms through which they are paid for their services, the author observes. He suggests that hospitals and the public work more closely together in planning for both immediate and long-range goals—in attempting to discern where they are going and how they are to get there.

HOSPITALS are facing many problems that have not beset them so seriously before. Some of these problems include: how to organize service effectively and efficiently in times of rapid scientific change, population growth and increases in chronic illness and aged persons; how to develop positive relationships between hospitals and their medical staffs, particularly the staffs in radiology, anesthesiology, pathology and physical medicine; how to meet the needs for capital, the cost of nursing and other paramedical education and the indirect cost of research.

There is one problem, common to all hospitals, that needs serious consideration. Perhaps it can be phrased thus: To what extent does the pattern of payment to hospitals for patient care influence the functioning of hospitals and their role in the community? In particular, how does this problem refer to the pressures brought upon hospitals by the movements of various types of third-party payment?

PATTERN OF PAYMENT

Of course, hospitals have always been influenced by the pattern of payment for their services. In the United States and Canada, hospitals have successfully grafted private patient care and the payment this brings in to the old charitable hospital. In Great Britain, this does not occur, and the British voluntary hospitals cannot survive independently. Even in this country, payment patterns vary widely from place to place and affect hospital functioning accordingly. For example, on the East coast most short-term hospitals have a mixture of private and ward patients, part of whose care is paid for or subsidized by public agencies. In California, on the other hand, public hospitals (county) care for most of the low-income patients, and voluntary hospitals have almost all private-paying patients. Then, of course, there are federal hospitals to care for special groups, such as veterans, members of the armed forces and their dependents and merchant seamen, etc.

For this discussion, however, the voluntary general hospital for short-term patients that has both private and ward patients will be considered. In these hospitals, much of the care is paid for by patients and third parties, including public welfare and other public agencies, but also these hospitals provide substantial free service to the needy and the medically indigent as inpatients or outpatients.

BLUE CROSS

This pattern of payment suggests several questions. First, how have such hospitals been influenced by patterns of payment for their services to patients and second, has this influence been good or bad or possibly a mixture of the two? Blue Cross, for example, is probably the largest single element in the payment pattern, and there is no doubt that it has helped hospitals (and patients) with finances. Yet, when Blue Cross *rates* of *payment* have become rigid, although the situation demands flexibility, or the coverage excludes services such as anesthesia, Blue Cross, partly by virtue of its size in many communities, has forced hospitals to function in accord with the pattern it sets rather than in a pattern most desirable to the hospital. If Blue Cross underpays for its members, non-Blue Cross patients must pay more; if Blue Cross excludes anesthesia, some other way must be found to pay for this service.

The typical Blue Cross-Blue Shield contract, by limiting its benefits almost exclusively to inpatients, has a tendency to drive patients into the hospital. So also has the typical commercial insurance policy for hospitalization and surgery. Who knows how many general hospital beds have been constructed and are occupied today because of this influence?

MAJOR MEDICAL

Now there is a new pattern of

Dean A. Clark, M.D., is general director, Massachusetts General Hospital, Boston.

This article was adapted from a presentation before the 1959 annual meeting of the Greater New York Hospital Association.

so-called "major medical" insurance. This program is too new for its influence on hospitals to be evaluated accurately. The fact that its benefits are *not* limited to inpatient care may tend to keep people out of hospitals, or at least get them out earlier. A similar effect on hospitals has definitely been shown by the comprehensive medical prepayment plans, usually associated with group practice.

In New York, for example, subscribers to these plans use hospitals only approximately two-thirds as much as typical Blue Cross-Blue Shield subscribers. Labor union health clinics, which provide a reasonably complete medical service for ambulatory patients, might well be expected to exert a similar influence although they do not usually cover care in the home. Suddenly a problem arises: What will happen to the Blue Cross-built hospital beds if patients get more of their care in clinics, physicians' offices and at home?

Another pattern of influence is Medicare. Medicare, until recently, provided hospitalization benefits at federal government expense for dependents of the uniformed services in either civilian or military hospitals. Then Congress decided that such dependents living at or near military posts must use military hospitals, unless given special permission to use a civilian hospital. This may not make much difference to hospitals in metropolitan areas but for a smaller hospital next door to a military post and geared to take care of the dependents, a serious problem arises. What happens to these hospitals when far fewer patients come than was planned? Furthermore, suppose the Medicare program is either expanded or contracted in the next several years? How are these hospitals to know how to plan realistically?

PUBLIC WELFARE

Another example of these outside forces that affect hospital planning is the effect on hospitals that public welfare department plans have regarding payment for the care of persons receiving public assistance, or of the medically indigent. If, as is the case in Massachusetts, public welfare departments were to provide a broad and balanced range of hospital-medical benefits for inpatients and outpatients and for nursing home care and if payments for these services were in amounts approaching their true cost, then a healthy outcome for hospitals could be expected. But what is the effect of welfare department plans that pay hospitals inadequately, or place rigid limits on drug supplies, home care, or rehabilitation services?

HOSPITAL FUNCTIONS INFLUENCED

Whatever the payment plan—private, nonprofit, or governmental—hospitals have very little to say in the matter and are influenced in every one of their functions by

HOSPITAL DISASTER PLAN INCLUDES A MOVIE STUDIO

The disaster plan of Saint Joseph Hospital, Burbank, Calif., has the use of one facility that is unavailable to most hospitals—space in a movie studio for handling any overflow of casualties.

The Walt Disney Studio is situated across the street from the hospital and is an integral part of the hospital's disaster plan. In the event of a serious disaster, additional bed space for the victims would be made available at the studio. Casualties would be "hospitalized" on sound stages and in the auditorium, as well as in two first-aid stations.

Walt Disney is a member of the hospital's advisory board and has cooperated through the years in many special hospital events. This is why "casualties" in a recent disaster exercise conducted by the hospital in cooperation with the Burbank Civil Defense Office found themselves "crashing" the studio without prior appointment. ■

FIRST-AID is given to two "casualty" victims at the Walt Disney Studio first-aid department during a disaster exercise with Saint Joseph Hospital. The studio handled more than 20 "disaster" victims during the exercise.

the pattern of payment for their services. If a hospital has little or no endowment income and very inadequate payments—or none at all—from public welfare agencies, is it fair to expect the private patient to pay, at least in part, for the care of the needy and the medically indigent? Most hospitals do expect this, whether they admit it or not. If this is fair, why should the noninsured private patient bear the brunt? Shouldn't Blue Cross and commercial insurance, with their large resources and their capacity to spread the bill over all their policyholders, be expected to take fair share of the costs of care for the needy?

MEDICAL EDUCATION

Finally, for those hospitals carrying the responsibility of educating medical personnel, what effect is the pattern of payments having on their educational programs? Obviously, some patients who once were "teaching material" are now seeking care as private patients, because they have the money and prefer this type of care. Many more patients who would be glad to come to wards or clinics will be *pushed out* of our teaching hospitals, because they are "above income limits". What, then, happens to medical education and house officer training? Again the remedy is simple: Raise income limits for wards and clinics to a much higher level or remove them altogether. If the service is good, patients with money will use it. Would this compete with private practice? Of course it would. But it seems likely that the private practitioner, if he fully understood that the future of medical education in nongovernmental hospitals in this country was at stake, would gladly suffer the very limited competition this would provide. Remember, there are only 150 to 200 hospitals in this country at which medical students are taught, and only approximately 1000 hospitals with internships and residencies. So the practitioner has little to fear.

At any rate, it is the *payment pattern, not* the hospitals, which is responsible for exacting *these* changes in the functioning of hospitals. Hospitals must respond to the payment pattern or close up.

But, on the other hand, should hospitals stand by while a sometimes heedless public manipulates them by means of the payment pattern? Definitely not. There are at least three things hospitals should do.

PUBLIC RESPONSIBILITY

First, and perhaps most important, a campaign should be launched to show the public that *it*, not the hospitals, determines what the functions of the hospitals shall be. Most people don't realize that it is *their* demands, usually expressed through payment pattern, that shape hospital functions. If the public wants hospitals to continue service and to improve teaching and research, then public effort must be made to bring consistency into the amounts paid under the prevailing plans and also into the services these plans cover and the population they care for. In brief, if the public wants to make the most effective use of hospitals, the payment pattern must include not only adequate payment for hospitalization for most of the population but also adequate payment for a comprehensive range of medical services.

The public must understand this matter. The hospitals are not responsible for the problem. If the public decides that another kind of hospital system shall prevail, this should occur. There is nothing permanent about the voluntary short-term general hospital. It can be replaced with some other type of hospital, such as a government-owned or private hospital. A series of Blue Cross-owned hospitals, company hospitals, labor union hospitals, insurance company hospitals, workmen's compensation hospitals, etc., could replace the voluntary general hospital. All of these hospitals already exist in this country, and if the payment pattern encourages them, they will take over—with a speed that will surprise many. If this group of special interest hospitals is what the public wants, this is what it will get.

HOSPITAL FINANCING

Second, if the public does *not* want a change in hospital systems but, instead, wants to preserve and improve voluntary community hospitals, then the public—and the hospitals themselves—must see to it that these hospitals are financed for the functions they are supposed to perform. The great organized agencies paying for hospital care must pay the full cost (*not* excepting depreciation, the costs of education and the indirect costs of research) of the hospital services. Some kind of intelligent effort must be made to fit hospitalization, as such, into a general over-all pattern of payment for medical care.

Medical care is moving into an era where the premium is on long-continued health supervision, preventive medicine, care of chronic illness and rehabilitation. Those who want to strengthen the voluntary general hospital must push for a pattern of payment that will recognize these facts. Failure to make the pattern of payment for hospitalization conform to present-day medical realities will, ultimately, result in the failure of our hospitals.

ROLE OF HOSPITALS

Finally, the short-term voluntary general hospital needs to be reorganized. An accurate accounting system that can be analyzed and compared in some sort of uniform manner needs to be adopted. Without such an accounting system, hospitals can't expect to be paid for the true cost of their services.

Hospitals should also charge and receive fees for professional services from all ward and clinic patients. Today, a large proportion of hospital inpatients, ward as well as private, and a small but increasing proportion of hospital outpatients have some form of insurance against the cost of physicians' services. In many instances, both Blue Shield Plans and commercial insurance companies are refusing to pay professional fees of ward and clinic patients. What possible justification is there for this refussal? The physician's services have been rendered and they have cost something, even if only the inadequate salary of a house officer. How can Blue Shield and the commercial insurance companies simply *pocket* such fees after premiums have been paid for them? The only justification is that a

(Continued on page 129)

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*Tyler, V.R.: *Consumer Evaluation of Reprocessing Technics for Unused Surgical Sutures, unpublished report.*

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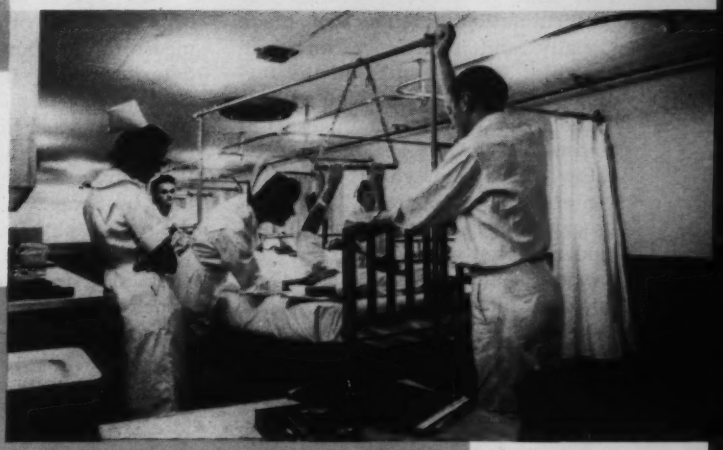

INTENSIVE CARE: a hospital state of mind

by RONALD YAW

The intensive care unit in the general hospital is the fruit of a state of mind which, according to the author, focuses the human and material resources of the hospital on a small number of critically ill patients.

AFTER TWO-AND-ONE-HALF years of experience with operation of an intensive care unit, several patterns and concepts concerning intensive care units in general have emerged.

The first decision to be made concerns the operating philosophy of the unit. More specifically, this means who and what types of patients are to be cared for in such a unit and under what circumstances? Where do these patients come from and where do they go to? These patients will be both medical and surgical with an increasing emphasis on the medical emergencies. It is a serious mistake to consider the intensive care unit as only an extension of the recovery room.

Another psychological consideration is the "never-full" concept. There must always be an empty bed in such a unit. First priority should be given to new admissions to the hospital, because all too often in these overcrowded days, the critical emergency situation has to be taken care of in improvised accommodations. Second priority should be given to transfers from within the hospital. The lowest priority should be given to transfers from the recovery room.

Separating male and female patients has not been a problem in our experience. The cubicles are screened, of course, but we have found it entirely feasible to have both male and female patients in close proximity without resentment on the part of either the patients or the public.

Age of the patient has been a problem, so a separate intensive care unit for pediatric patients is almost a necessity simply because everything needed is of a different size from that needed for adults.

Many of the needed decisions can and should be made in advance of the opening of such a unit. Carefully spelled out definitions of the indications for patients to enter the unit as well as to leave the unit can be done in advance. Authority must be predelegated—not only from the medical staff to the nursing staff but also from one section of the medical staff to another. It is well, for instance, to have a committee representing different specialties given power to move patients out of the unit on an objective basis. It is also well to set up an illustrative list of diagnoses.

The list in use in our hospital includes: acute cardiovascular disease, such as severe coronary attacks; acute congestive heart failure; any embolic phenomenon; uremia; diabetic acidosis and diabetic coma; severe poisoning; gastrointestinal and bronchial pulmonary hemorrhages; complex skull and acute abdominal injuries; severe burns, and occasionally hip fractures that require considerable preoperative management. The key is in the word "complex", not continuous or even intensive, since the complexity of the treatment is the major determining factor for eligibility.

DETERMINING FACTORS

No hospital should venture into the field of intensive care with any idea of saving money, because these units actually are costly to operate.

In the opinion of the writer, the

Ronald Yaw is director of Blodgett Memorial Hospital, Grand Rapids, Mich.

arbitrary percentage-of-beds approach to determining the size of the unit is entirely wrong. The determination should be made locally and separately for each hospital, keeping in mind the following factors: What kind of hospital is it? Where is it in terms of severe highway accidents, etc.? How active and what type is the emergency department? Does it receive severe burn and major accident cases or does it have less serious emergencies? Another important factor is the nature of the medical staff. Does the hospital have services doing so called "big surgery"? The existence of an open-heart program, for example, would almost demand a good intensive care unit.

Staffing on this type of unit should average between 12 and 14 hours of care per patient day, in a ratio of roughly half professional and the rest carefully selected and trained subsidiary workers. Our experience has been that an elite corps concept is generated in the unit, with the nurses and aides finding the intensive care unit assignment a very rewarding experience. Some concern was expressed originally that perhaps the private duty nurses would be resentful of such a unit, but this has not developed. There usually are not enough private duty nurses to go around anyway and the level of complex care that is required somewhat overtaxes the person who very likely is a part-time nurse and part-time housewife.

EQUIPMENT AND LOCATION

Our experience has been that the standard recovery room bed is quite suitable, since it enables a patient to be transferred from the recovery room or from the recovery section of the emergency department without having to be moved from one bed to another. Piped-in oxygen is highly desirable and lighting should be at the level of care rather than comfort. If an emergency procedure is needed, no time should be lost looking for lights. Similarly, the unit must be very adequately supplied with medical equipment, such as sphygmomanometers, cut-down sets, etc., and provision should be made for the occasional heroic episode —the unexpected tracheotomy or thoracotomy.

This type of unit can well be a repository for the seldom used pieces of equipment that tend to deteriorate or to be misplaced. Such things as pacemakers, monitors and other intricate devices can be stored and maintained in the supply section of an intensive care unit.

From a physical point of view, the unit should be out of the public eye and in an air-conditioned area, which is as much or more for the comfort of the nursing staff as for that of the patients. Oddly enough, toilets should be provided both for the patients and for the personnel, because there will be patients receiving complex care who still can get up at times.

We strongly believe that an intensive care unit should be in a fairly open, undivided space, having the beds curtained with cloth cubicles. The concept of an intensive care unit as a series of rooms seems to defeat the purpose of permitting a direct view of the patient at all times.

The problem of the isolation patient is a real one and it would be well to have one or two areas where isolation patients requiring intensive complex care can be placed. Food is not much of a problem, since the stay in the unit is quite short and the patients do not eat normally while there.

Today, many novelties are being introduced into intensive care units, but many of them are of little or no value. Contraptions to view the patient around the corner or an elevated nursing station obliging nurses to climb a ramp are highly questionable "improvements". None of these devices and contraptions can really take the place of a good professional nurse knowing exactly what the patient looks like, feels like and smells like at any given moment.

In summary, an intensive care unit is not the way the bricks are arranged or the windows are placed or the equipment is assembled. Intensive care is a state of mind in which predelegated medical decisions are made and a dedicated group of nursing personnel can bring the total material and manpower assets of the hospital to a focus on a small number of patients. ■

NOTES AND COMMENT

Hazards of boric acid

The American Academy of Pediatrics, through its Subcommittee on Accidental Poisoning, has prepared a Statement on Hazards of Boric Acid, which will be sent to all pediatricians through the Academy's publications and to other interested persons in the health field through other publications.

Boric acid, an old agent, known also as H_3BO_3, boracic acid or orthoboric acid, is still a troublemaker in hospitals. Boric acid usually consists of colorless and odorless crystals or granules, or a white powder, which are prepared by the action of sulfuric acid on borax or sodium borate.

Medicinally, it is used in eye solutions, as an acidifying agent in treating the irritation produced by ammoniacal diapers of infants, in dermatology as an ointment (either singly or in combination with other ingredients) and in gargles and mouthwashes.

The Food and Drug Administration issued a statement on Jan. 30, 1954, to the effect that borated talcum powder containing 5 per cent or less of boric acid is safe for use as dusting powder on babies.

The Academy's statement on the hospital use of boric acid reads as follows:

"The presence of boric acid in hospitals, especially in the newborn nursery and pediatric sections, constitutes a substantial health hazard and has been associated with many accidental deaths over the years. Less than a teaspoonful of boric acid has been fatal to infants. Since it is possible to provide satisfactory care for patients without the presence

of this toxic substance, it is recommended that rigid controls over its hospital use be required and that they include a recommendation for the elimination of boric acid from the newborn nurseries and pediatric wards of all hospitals.

"Physicians, pharmacists and other professional personnel should carefully weigh the hazards involved in introducing this substance into other departments of the hospital and should place very exact and specific limitations on its use and on the disposal of unused residues." ■

Standards for establishing a cardiac surgical service

In the recent history of medicine, few advances have equaled the dramatic progress made in the surgical treatment of diseases of the heart. The mastery of new surgical techniques for repairing heart defects, and for keeping the patient alive while this is done, has restored thousands to normal or near normal life. These medical triumphs have captured the imagination of the press and its readers, and have led to tacit pressure on hospitals to provide the skills and facilities necessary to perform these therapeutic feats.

It is important, however, that hospitals faced with deciding whether to establish a cardiovascular surgical service should know something of the responsibilities involved, and should have some understanding of the resources required for its success.

The physician, of course, must shoulder the burden of decision in terms of the probable prognosis of the patient's present condition and the risks and possible outcome of cardiovascular surgery.

The establishment of a cardiovascular surgical service demands more resources in personnel and equipment than any other service. In addition, under present methods of pricing surgical services, establishing a cardiac service will mean a heavy deficit operation, for which the hospital must be financially prepared.

Essential for every hospital considering or planning the establishment of a program of cardiac surgery is the report—"Standards for Centers Caring for Patients with Congenital Cardiac Defects"—of the Committee on Congenital Heart Defects of the American Heart Association.*

The report stipulates the personnel and facilities required for successful establishment of a cardiac surgical service. It should be useful to any hospital considering establishment of such a service.

Accurate diagnosis of congenital cardiac malformation is a prerequisite to cardiac surgery; therefore, a diagnostic center is of prime importance for any hospital in which cardiac surgery is performed. The standards cover such matters as (1) the diagnostic staff, (2) diagnostic facilities, (3) diagnostic services, (4) basic requirements in the surgical care of patients and (5) aftercare of patients. ■

*Copies of the "Standards" are available from the American Heart Association, Inc., 44 East 23rd St., New York 10, New York.

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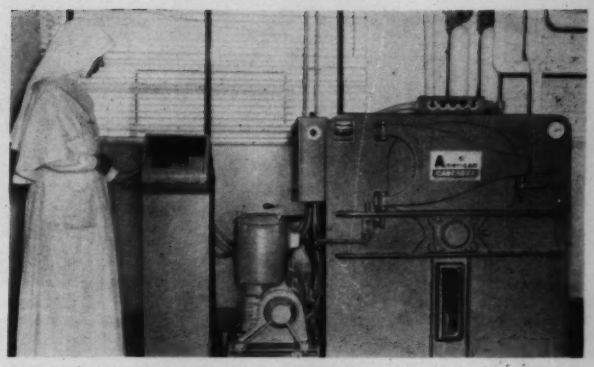
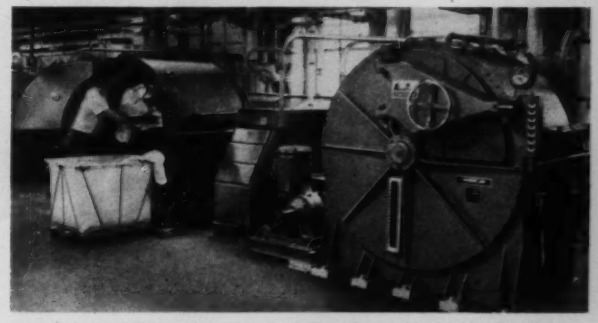


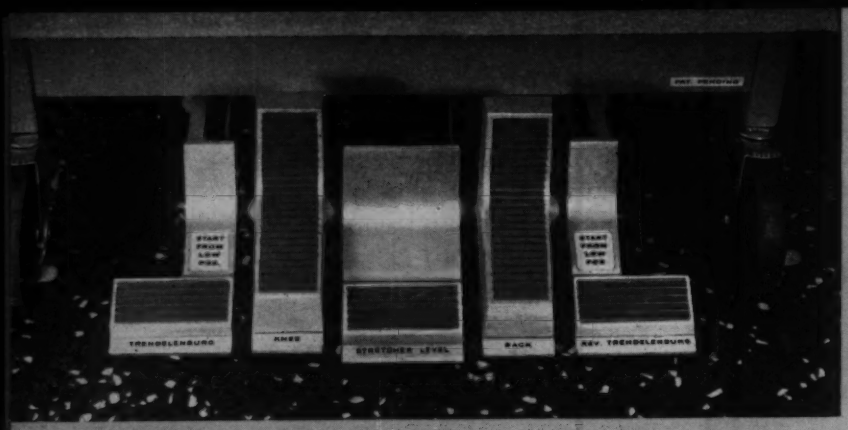
This CASCADEX Washer-Extractor with SELECTRO Washing Control handles all the laundry at new 50-bed St. Joseph's Hospital, Nogales, Arizona. Hospital reports better quality work, faster return of linens to service, smaller linen inventory and improved working conditions.

"Our CASCADEX does not require constant attention, and we do not have wet floors, as when transferring clothes from washer to extractor," is report from Mr. Alfred Trouten, Laundry Supervisor at Martins Ferry (Ohio) Hospital. Also, "the CASCADEX gives us a cleaner wash, and the reduced handling of linens makes the work much easier."



At Our Lady of Fatima Hospital, North Providence, Rhode Island, these two CASCADEX Washer-Extractors with Full-Automatic Washing Controls saved enough floor space to eliminate building an addition to the laundry. Reduced handling of work also cut labor costs, improved morale and efficiency in the laundry washroom.

At Long Beach (Calif.) Community Hospital, this CASCADEX Washer-Extractor with SELECTRO Washing Control has greatly improved employee working conditions. The hospital reports much less labor turnover and absenteeism, much greater production and efficiency.



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Equally important, the Borg-Warner bed is a marvel of simplicity. The single, low-amperage motor operates the bed through all positions: Trendelenburg, Reverse Trendelenburg, Stretcher Level, Knee and Back Rest, Fowler, High-Low, and Vascular.

In low position, the Borg-Warner bed is only 16 inches from the floor—at stretcher level a full 34 inches, 4 to 8 inches higher than any other motorized bed.

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equipment and supply review

New product descriptions included in this section are condensed from reports furnished by manufacturers and distributors. Descriptions are included here for informational purposes and such inclusion does not constitute endorsement by the American Hospital Association.

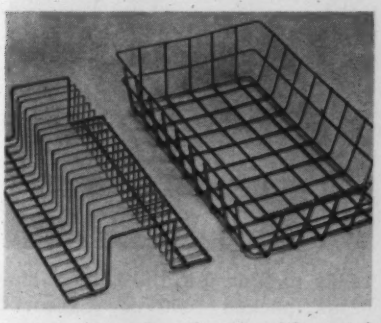
Plastic stopper (4F-1)

Manufacturer's description: This light weight, resealable glass container for liquids, powders or pills, pro-

vides a locked-on, one-piece, plastic closure, which can be removed by using one hand. Other features are optical clarity, stability, uniform fill points, uniformity of weight and ease of labeling. *Lumelite Corp., Dept. H4, Pawling, N.Y.*

Glove rack (4F-2)

Manufacturer's description: For handling gloves during and after sterilization, this glove rack comes in two sections—a removable inner rack in an outer utility basket. The utility basket can be used for sterilizing packaged syringes and other items. Because the rack can be removed for drying, the autoclave can be re-used and the inner rack may be placed directly on sterile storage shelves or on a cart for delivery without handling packaged gloves. Made of lightweight stainless steel with reinforced handles, the utility basket measures 20½ in. x 12½ in. and the inner rack measures 16¾ in. x 9½ in. Rigid, heavy wire construction permits maximum passage of steam, mini-



mal contact of packages with metal surfaces and avoids excessive reflected heat. *Edward Weck & Co., Dept. H4, 135 Johnson St., Brooklyn 1.*

Washer-extractor (4F-3)

Manufacturer's description: Designed for smaller hospital laundries, or for special work in large hospital laundries, this automatic launderer washes and extracts 40 lbs. of work in 29 min. Enclosed in a white baked enamel, steel cabinet, the washer has a stainless steel tub and cylinder, an interlocked tub door,

electrically operated inlet and drain valves and requires a space 45 in. wide x 42 in. deep with either side flush against the wall. *American Laundry Machinery Industries, Dept. H4, Cincinnati 12.*

Food trays (4F-4)

Manufacturer's description: Loading trays with hot and cold foods from different stations is now possible with this three-piece tray. The unit con-

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▶ If you wish to have your name sent direct to the manufacturers of products and distributors of literature described in this review, check the appropriate items on this coupon, sign your name and address, clip and mail to the Editorial Department of HOSPITALS, J.A.H.A., 840 North Lake Shore Drive, Chicago 11, Illinois.

PRODUCT NEWS

- ____ Plastic stopper (4F-1)
- ____ Glove rack (4F-2)
- ____ Washer-extractor (4F-3)
- ____ Food trays (4F-4)
- ____ Generator (4F-5)
- ____ Scrub file (4F-6)
- ____ Identification unit (4F-7)
- ____ Bath mat (4F-8)
- ____ Plastic catheter (4F-9)
- ____ Portable freezer (4F-10)
- ____ Food release (4F-11)
- ____ Two-way mobile communication (4F-12)
- ____ Tap water demineralizer (4F-13)

PRODUCT LITERATURE

- ____ Deep frying (4FL-1)
- ____ Fluorescent lighting (4FL-2)
- ____ Cleaning procedures-floor coverings (4FL-3)
- ____ Mats and treads (4FL-4)
- ____ Inventory control procedures (4FL-5)
- ____ Portable fire equipment (4FL-6)

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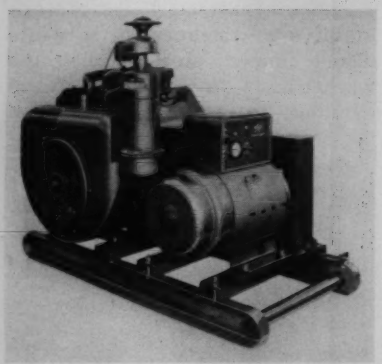
sists of two trays, measuring 11¼ in. x 16½ in., which nest side by side in a larger tray measuring 16½ x 22½ in. In service and assembled separately, one hot meal and one cold meal can be carried to their destination on one tray. The nonporous trays are available in 12 colors, do not warp, bend, dent, rust, or rot and can be cleaned in steam or hot water. *Molded Fiber Glass Tray Co., Dept. H4, Linesville, Pa.*

Generator (4F-5)

Manufacturer's description: Powered by an air-cooled gasoline engine, these generators are rated at 12,000 watts A.C., and are equipped for remote starting. This 12,000-watt,



115/230 volt, 60 cycle generator will carry such loads as a five h.p. motor, plus 6000 watts of simultaneous resistive load. *Wincharger Corp., Dept. H4, E. 7th & Division Sts., Sioux City, Iowa.*

Scrub file (4F-6)

Manufacturer's description: Made of stainless steel, this scrub file was designed as a companion piece to the surgeon's hand brush. The file clips onto the inside of the scrub-brush handle permitting both to be autoclaved. The point of the file is diamond-shaped for more

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Weck Stainless Steel Scrub File
Surgeon's Brush with file clipped inside

thorough cleaning. The file is noncorrosive and rustproof. *Edward Weck & Co., Dept. H4, 135 Johnson St., Brooklyn 1.*

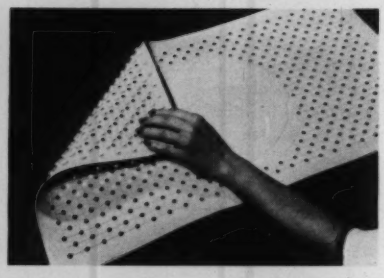
Identification unit (4F-7)

Manufacturer's description: These patient identification cards, used with the stainless steel chart holder, are precut, preprinted, color-coded and

ready to slide into the holder. The cards, packed 1000 per package, are used to identify type of admittance, doctor, treatment, or special handling. *Beam Metal Specialties, Inc., Dept. H4, 25-11—49th St., Long Island City 3, N.Y.*

Bath mat (4F-8)

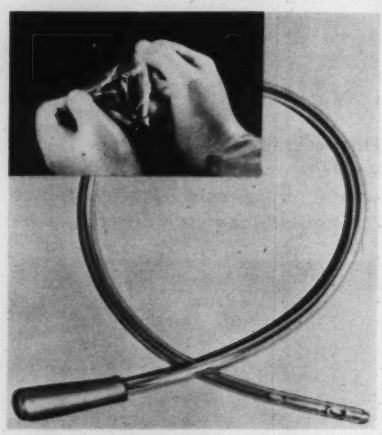
Manufacturer's description: Made of soft,



cushiony rubber, this mat has 688 suction cups that help prevent slips and falls. Machine washable, the mat is almost completely unaffected by soaps, detergents, or bleaches. It is 14 in. x 26 in. and is available in green, white or pink. *Rubbermaid, Inc., Dept. H4, Wooster, Ohio.*

Plastic catheter (4F-9)

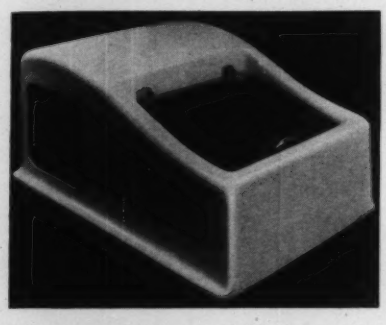
Manufacturer's description: Sterile-packaged in a transparent film envelope and made in one size, this plastic urethral catheter has exterior flaps which peel back from the sterile interior making it ready for use. The thin wall construction helps provide the desired drainage of a



large catheter without the distention of a large outside diameter and aids in giving the catheter a wide range of use. *C. R. Bard, Inc., Dept. H4, Summit, N.J.*

Portable freezer (4F-10)

Manufacturer's description: This portable, sanitary freezer provides the maintenance of sub-zero temperature which is required for slushpacks and other cold temperature storage.



The compact unit is furnished with a white, washable, fiberglass exterior, and optional colors are available to permit differentiation of contents or department use. *Frosty-Glass Co., Dept. B-40/H4, Box 762, Santa Monica, Calif.*

Food release (4F-11)

Manufacturer's description: A food release is now available in 2 convenient forms: a 20-oz. aerosol can and also in five, 30 and 54-gal. bulk containers. This food release can be used on iron, stainless steel, enamelware, aluminum, glass, pyrex, or most other materials with which food might come in contact. Heavily crusted roasters, casseroles, waffle irons, griddles, gelatin molds, sauce pans, pots and skillets can easily be rinsed clean. The formula is patented and contains no silicones. *Gibraltar Industries,*

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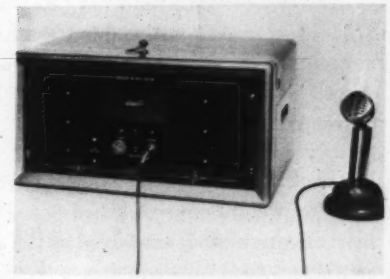
Inc., Dept. H4, 469 E. Ohio St., Chicago 11.

Two-way mobile communication (4F-12)

Manufacturer's description: This small, lightweight, FM, mobile unit has a 15-watt transceiver which may be used either as a base station or mobile unit. It operates on either



six, 12, or 115 volts and may be transferred from vehicle to vehicle or vehicle to office by simply using

the proper power cord for the voltage being utilized. *Aeronautical Electronics, Inc., Dept. H4, P.O. Box 6527, Raleigh, N.C.*

Tap water demineralizer (4F-13)

Manufacturer's description: Contained in a one-pt., plastic squeeze bottle, this chemical solution removes minerals and other impurities from tap water, making it applicable for use in steam irons, bottle warmers, vaporizers and other appliances for which distilled, scale-free water is recommended. The squeeze bottle has a removable leak proof cap, can be refilled repeatedly and makes up to 10 gals. of distilled water. When all of the resin beads in the bottle have turned yellow, refills should be ordered. *Distill-O-*

Co., Dept. H4, P.O. Box 21111, Dallas 11.

product literature

SEE COUPON, PAGE 71

Deep frying (4FL-1)—In these eight pages, some of the most frequently asked questions about deep frying are answered. This brochure can help hospital personnel profit even more from their deep frying operations. *Durkee Foods, Dept. H4, 900 Union Commerce Bldg., Cleveland 14.*

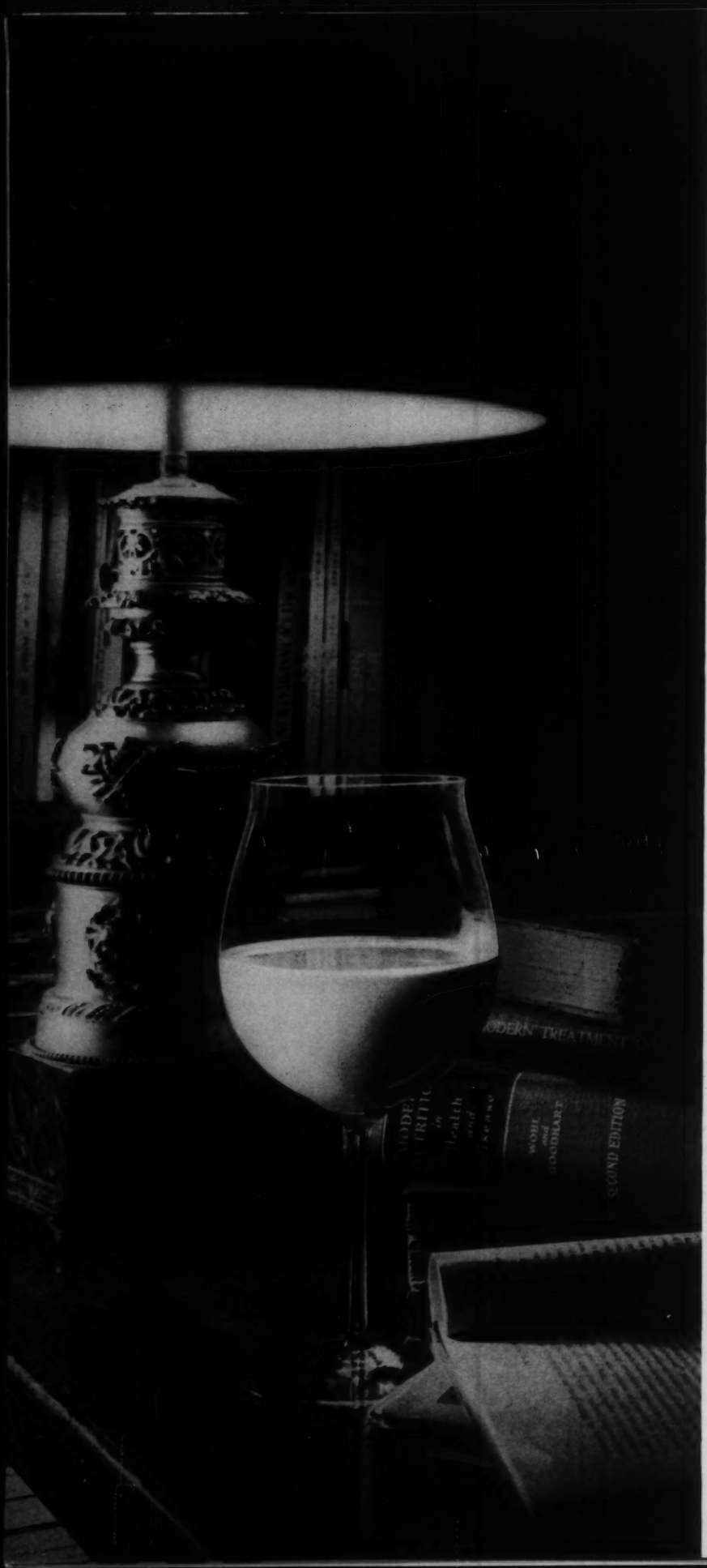
Fluorescent lighting (4FL-2)—General information on recessed fluorescent lighting and 10 diffusing elements is available in this 40-page booklet. Fully illustrated with photographs and technical drawings, contents include construction features, specifications, maintenance features, a diffuser check chart, illustrated mounting methods, accessories and trim details for sides and ends. *Globe Illumination Co., Dept. H4, 2121 So. Main St., Los Angeles 7.*

Cleaning procedures-floor coverings (4FL-3)—Included in this booklet is general information on how to clean and polish different types of floor coverings. Some of the specific procedures described are buffing, damp mopping, polishing and waxing of floors. *Finnell Systems, Inc., Dept. H4, Elkhart, Ind.*

Mats and treads (4FL-4)—This booklet describes specific types of floor mats, stair treads and matting runners that are suited for most safety-maintenance needs in hospitals. The catalogue also illustrates the most popular materials used in the manufacturing of each of these products. *American Floor Products Co., Dept. H4, 4922 Wisconsin Ave., N.W., Washington, D.C.*

Inventory control procedures (4FL-5)—Practical procedures for inventory control are outlined in this four-page, engineered maintenance pamphlet. Among the topics covered are desirable inventory levels, automatic reminder systems for reorders, housekeeping supplies for ready inventorying, prevention of waste in housekeeping materials, storing, marking and color-coding supplies and coordination of housekeeping and purchasing reorders. *Puritan Chemical Co., Dept. H4, 916 Ashby St., N.W., Atlanta 18.*

Portable fire equipment (4FL-6)—This 16-page catalogue provides complete information on portable, hospital interior fire safety equipment. There are nine categories of hand portable models described, plus fire hose and extinguisher wall cabinets featuring steel, stainless steel and aluminum models. Also included are hose racks, hose reels, angle valves, fire hose, fire hose nozzles, siamese conneetions and related fire control accessory equipment, plus engineering and specification data. *Fyr-Fyter Co., Dept. H4, Customer Services, 221 Crane Street, Dayton, Ohio*



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A DRUG PREPACKAGING SYSTEM GEARED TO OUTPATIENT NEEDS

by RODERIC M. BELL

The author describes the development of a drug prepackaging system for a large hospital which improved service, maintained quality and reduced costs. After more than two years of operation, the program has saved $25,000 annually.

PARKLAND Memorial Hospital, Dallas, Tex., was designed and built to serve the indigent patients of Dallas County and to provide certain services that were not offered in the voluntary hospitals of the community. A new building containing 575 beds and 50 bassinets was dedicated in the early fall of 1954.

With the move into the new building, it became apparent that a new method for drug dispensing must be developed if the rapidly increasing number of patients was to be served efficiently. Action to solve this problem began in 1956 with the planning of a new outpatient clinic, which, because of lack of funds, had not been undertaken at the same time as the new inpatient facilities.

The problem appeared to be simply this: Could a plan be developed that would permit the rapid dispensing of 400 to 500 prescriptions a day at the lowest possible cost? Could this system also work in such a way that long lines of patients at the drug window would be eliminated?

In the original hospital building, one central drug room served both inpatients and outpatients. It was small, crowded and inefficient. A normal line included 30 outpatients. Under the original system, a prescription was presented, filled, labeled and the druggist collected payment according to the classification on the patient's clinic card. Fully one-third of the pharmacist's time was spent making change, or attempting to collect.

In 1956, when funds became available for a new outpatient building, the assistant administrator and the chief pharmacist started planning a system that the hospital could afford and that would eliminate long waits by patients. It was apparent that to continue the existing system would require two additional pharmacists at a salary cost of at least $12,000 a year.

DECISIONS AND ACTIONS

After careful study, the conclusion was reached that the problem could best be solved by installing a system for prepackaging the most frequently used drugs in the quantities most commonly prescribed. Two alternatives were considered: first, the purchase of drugs packaged in various retail sizes, and, second, the employment of two additional pharmacists. It is important to note that the hospital uses a formulary based on United States Pharmacopeia standards and not on trade names.

A tabulation of 20,000 previous prescriptions was made to determine what to prepackage and in what sizes. Approximately 350 drugs were consistently and routinely used. Almost 65 per cent

At the time this paper was written, Roderic M. Bell was assistant administrator, Dallas County Hospital District. Mr. Bell is now administrator, Presbyterian Hospital of Dallas, Texas.

Table 1

TEN MOST COMMONLY PREPACKED DRUGS

Description	Purchased In Lots of	Standard Rx Size	Cost in Cents With Container	Cost in Cents to Buy Identical Size	Annual Drug Saving
Ferrous Gluconate 5 gr. Coated Tabs.	200,000	100	.15½	.33	$ 875.00
Phenobarbital ½ gr.	300,000	100	.07	.20½	540.00
Phenobarbital and Belladonna Tabs.	150,000	100	.06⅓	.34	828.00
Digitoxin 0.1 mg	150,000	100	.09½	.31	645.00
Aspirin 5 gr. Tabs.	300,000	100	.08¾	.19	615.00
Hexavitamins Tabs. N.F.	200,000	100	.32	.76	1760.00
Pentaerythritol Tetranitrate 10 mg	100,000	100	.19	.42	690.00
Reserpine 0.25 mg	150,000	100	.09	.45	1620.00
Potassium Chloride 5 gr. EC	60,000	100	.15⅓	.40*	492.00
Diphenylhydantoin Sodium 0.1 Gm Caps	150,000	100	.36½	.52	405.00
					$8470.00

The above are not necessarily in ascending or descending order of usage.

Lots purchased represent one routine order by this department; usually two or more are placed annually.

Cost per package including container does not include labor.

Cost to purchase was figured on the average price of the lowest five published prices, and 10 per cent deducted from that figure, then tested by checking with a manufacturer and adjusted to the most reasonable estimate.

Savings annually based on total number of tablets or capsules purchased annually and divided by the most standard prepackage size: Example: On Ferrous Gluconate, we will save on approximately 5000 packages at 17½ cents per package.

*Estimated

of these drugs were ordered in standard sizes; for example, antibiotics in 16's, aspirin in 50's, multivitamins in 100's, etc. The remaining 100 drugs were usually ordered in one of three sizes.

Upon the completion of this survey, the proposed program, together with the lists of drugs, was presented for study, evaluation and adjustment by the chiefs of services of the outpatient department. All questions relative to quantities of drugs ordered were referred to the appropriate chiefs of service. This was considered the practice of medicine and not a prepackaging problem. As the result of very helpful suggestions and some adjustments, a firm list of 331 drugs was recommended to the formulary committee for approval.

When the formulary committee approved the program and the list of drugs, several conclusions were reached as a by-product of the basic decision. First, the new outpatient drug room would be limited to dispensing. Second, a substantial variety of nonprepackaged items would be carried in inventory, but not a complete stock. Third, a pneumatic tube would be installed between the outpatient drug room and the central pharmacy. Fourth, the drug room would be located adjacent to the clinic cashier, with a pass-through window so the cashier could collect for drugs. Thus, valuable pharmacist time would be saved and cash control would be assured.

PREPACKAGING WORK AREA

These elements were incorporated into the design of the new building as recommended. A second step in the program was the planning and equipping of a prepackaging work area in the central pharmacy. This consisted of the installation of a 14-foot counter with sink, the purchase of a tablet counting machine and a department store type label printer. Small stick-on labels, one-half by three-fourths inch, were speedily printed. Each label carried in code the item, cost, date of repackaging and number of units. Approximately $1200 was invested in equipment and new shelving to start the operation.

To provide precise internal controls, a work sheet was designed to reflect all pertinent facts on each prepackaging operation. The control sheet provides for the recording of name of drug, manufacturer, lot number, cost to hospital, instruction for packaging, size of container and final count of packages. In addition, the sheet shows time required for the "run" and signatures of those responsible for the operation. A comment column provides space for remarks, such as "sticky", "dusty" or "ran well". A registered pharmacist always starts a "run" and checks the finish.

Prepacks are ordered by the outpatient drug room from the central pharmacy as needed. As most of the clinics are specialized and are held for a half-day two or three times a week, the pharmacist moves drugs peculiar to that day to the front counter to save time. Preprinted instructions on labels also saves typing time at the dispensing counter.

Since the success of the program depended upon the understanding and cooperation of the hospital medical staff, an intensive educational program was started. Every physician was supplied with a complete list of the prepackaged formulary. Costs of drugs were also shown. Additional lists were placed in all areas in the clinic where prescriptions were written and explanatory talks were given at chart conferences for each of the services. Strong emphasis was placed on the availability of standard sizes, but any size order would be honored by the pharmacy. No quantity substitutions were permitted without consent of the ordering physician. Every house officer and attending physician was

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Table 2

TEN TYPICAL PROPRIETARY PREPACKED DRUGS

Description	Purchased In Lots of	Standard Rx Size	Cost With Container	Cost to Buy Identical Size	Annual Drug Saving
Cosa Tetracyn® 250 mg	100	16	$4.922	$5.10	$1260.96
Diamox® 250 mgm	5000	25	$1.334	$2.16	165.20
Chloromycetin® 250 mg	100	16	$4.922	$5.10	580.53
Gantrisin® 500 mg	1000	100	$2.5512	$2.94	583.20
Mysoline® 250 mg	1000	100	$3.919	$4.33	82.20
Artane® 2 mg	5000	100	$1.013	$1.50	73.05
Erythromycin® 250 mg	100	16	$4.922	$5.10*	222.00
Kynex® 500 mg	5000	24	$1.458	$2.36	180.40
Diuril® 500 mg	1000	30	$1.726	$1.80*	74.00
Benadryl® 50 mg	1000	50	$0.9325	$1.05*	75.40
					$3296.94

*Not commercially available in our prepackaged size. This cost is extrapolated from the nearest size commercially available. Other prices herein are published prices.

familiarized with the program.

Within 30 days, more than 75 per cent of the prescriptions were for standard sizes. A second follow-up education program directed at a few physicians raised the ratio to 98 per cent of the total volume. Within six months, the operation was very smooth. One regular pharmacist with one typist helper consistently fill 350 prescriptions a day in the clinic. Very little patient waiting is necessary. After 2½ years, the program is very solid and is being extended to the commonly used inpatient drugs.

Table 1 (page 78) and Table 2 (above) tell the story of accomplishment in effecting substantial material savings. In addition to the drug savings, a minimum of $12,000 is saved each year in salaries, for a total of approximately $25,000 each year. ■

NOTES AND COMMENT

Proposed standards previewed for nursing home drug service

Some of the provisions of an upcoming group of standards for drug service in nursing homes were described before a group of hospital pharmacists meeting recently in New York by a representative of the U.S. Public Health Service, which has been engaged in formulating the standards for more than two years.

Kenneth R. Nelson Jr., consultant in administrative management of medical care facilities of the PHS Division of Special Health Services, said such standards are sorely needed because of the nation's 25,000 nursing homes, only a very small number employ a professional pharmacist on a consulting basis.

Mr. Nelson, speaking before the pharmacy section of the American Association for the Advancement of Science at its annual meeting at year's end in New York, said that the standards would be minimal, and that they are meant to be a guide for states that may want to use them as a basis for legislation.

"Most nursing homes are served by retail pharmacists who may never see the patient," Mr. Nelson said. "As a result, the important pharmacist-physician-nurse relationship is upset."

Questionable practices in nursing homes in the handling of drugs is not necessarily deliberate carelessness, Mr. Nelson said, but usually it is a case of the administrator's not realizing his responsibilities in providing protective measures and safeguards for patients.

PHARMACY COMMITTEE ESSENTIAL

The first standard in the guide, Mr. Nelson said, requires that nursing homes have a pharmacy committee or an individual advisory pharmacist. If the home has a committee, its membership should contain at least one licensed pharmacist.

"It is realized that this is a high goal," Mr. Nelson said, "one that is almost impossible to meet right now."

Another standard deals with automatic stop orders. Stop orders for drugs in nursing homes are particularly important, Mr. Nelson said, because physicians visit patients infrequently.

The standards also stipulate (1) that drugs be stored separate from cleaning compounds and other unrelated and potentially dangerous substance, (2) that drugs be handled only by a pharmacist, and (3) that nursing homes may not have on the premises any prescription drug not in individual dosage sizes unless a pharmacist is employed at least on a consulting basis.

TESTS OF PLASTICS DESCRIBED

Further progress in tests to discover the extent of interaction between plastics and drugs was reported by John Autian, Ph.D., associate professor of pharmacy at the University of Texas.

"No matter how small the number of incidences of untoward reactions between drugs and plastics, research is well worthwhile," Dr. Autian said.

Pharmaceutical manufacturers test the reactions between drugs and plastics, Dr. Autian noted, and reformulate the drug or use another plastic if there is a reaction. Likewise, most manufacturers of plastics for use in distributing drugs test their products. "The real threat," Dr. Autian said, "comes from marginal operators who market the same products but who do not do any testing."

Studies have shown that reactions between drugs and plastics take three forms, Dr. Autian said: leeching or migration, chemical reaction, and binding or absorption.

Dr. Autian described leeching as the release of substances from plastic to its immediate environment. In one test, he said, polyvinyl plastic released a substance into solvents commonly used in parenteral products. Polyethylene bottles may even release a substance into distilled water stored in them for a time, Dr. Autian said. In the case of plastic-hubbed needles, even though a very small surface is exposed to a drug, there is still a possibility that the drug may attack the plastic, he said.

Chemical reactivity, Dr. Autian explained, implies that part of a drug has reacted to part of the plastic. "Any drug sensitive to oxidation does not last long in a plastic container," he said in giving an example.

In binding, Dr. Autian said, there is absorption of a drug by the plastic. Some drugs having acidic bases have been shown to have been taken up by nylon syringes when stored for one week, Dr. Autian reported.

STANDARDS URGENTLY NEEDED

Standards for plastics with drugs are urgently needed, Dr. Autian said. Approval by the Food and Drug Administration is not necessarily adequate, he observed, since these standards apply mostly to foods.

Dr. Autian recommended that committees be formed in hospitals to evaluate plastic devices. He said hospitals are now purchasing plastic containers and devices for use in connection with drugs for which they have not been tested.

A suggestion that hospital pharmacists could enhance their position by engaging in clinical laboratory work was made by Prof. Alex Berman of the University of Michigan. Dr. Berman, in a discussion of hospital pharmacy in France, noted that the French pharmacists commonly do laboratory work that in this country is under the supervision of a pathologist.

In the audience discussion that followed, it was pointed out that a pharmacist who also did clinical laboratory work would be particularly valuable in a smaller community lacking facilities for this work. One audience member observed, however, that in view of the shortage of pharmacists, it would be wasteful for a pharmacist to do simple laboratory tests, and that such activity should be limited to more complex matters of biochemistry.

A system used by the U.S. Public Health Service to distribute drugs from a central dispensary to 24 outpatient clinics was described by Gabriel P. Ferrazzano, M.D., medical director, deputy chief of the Division of Hospitals. The service provides pharmaceuticals in prepackaged patient dosage units, operating in the same way as an emergency drug service, Dr. Ferrazzano said.

He said there was no reason why a similar system could not be set up on a regional basis among voluntary hospitals, with all subscribers using a single formulary. ■

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food service and dietetics

DINING area in the cafeteria of the Allegheny General Hospital, Pittsburgh, Pa., may be divided into six dining rooms by means of folding doors. One is for medical staff use.

EFFICIENT LAYOUT AND EQUIPMENT INCREASE CAFETERIA SALES

by RUTH SILVESTER

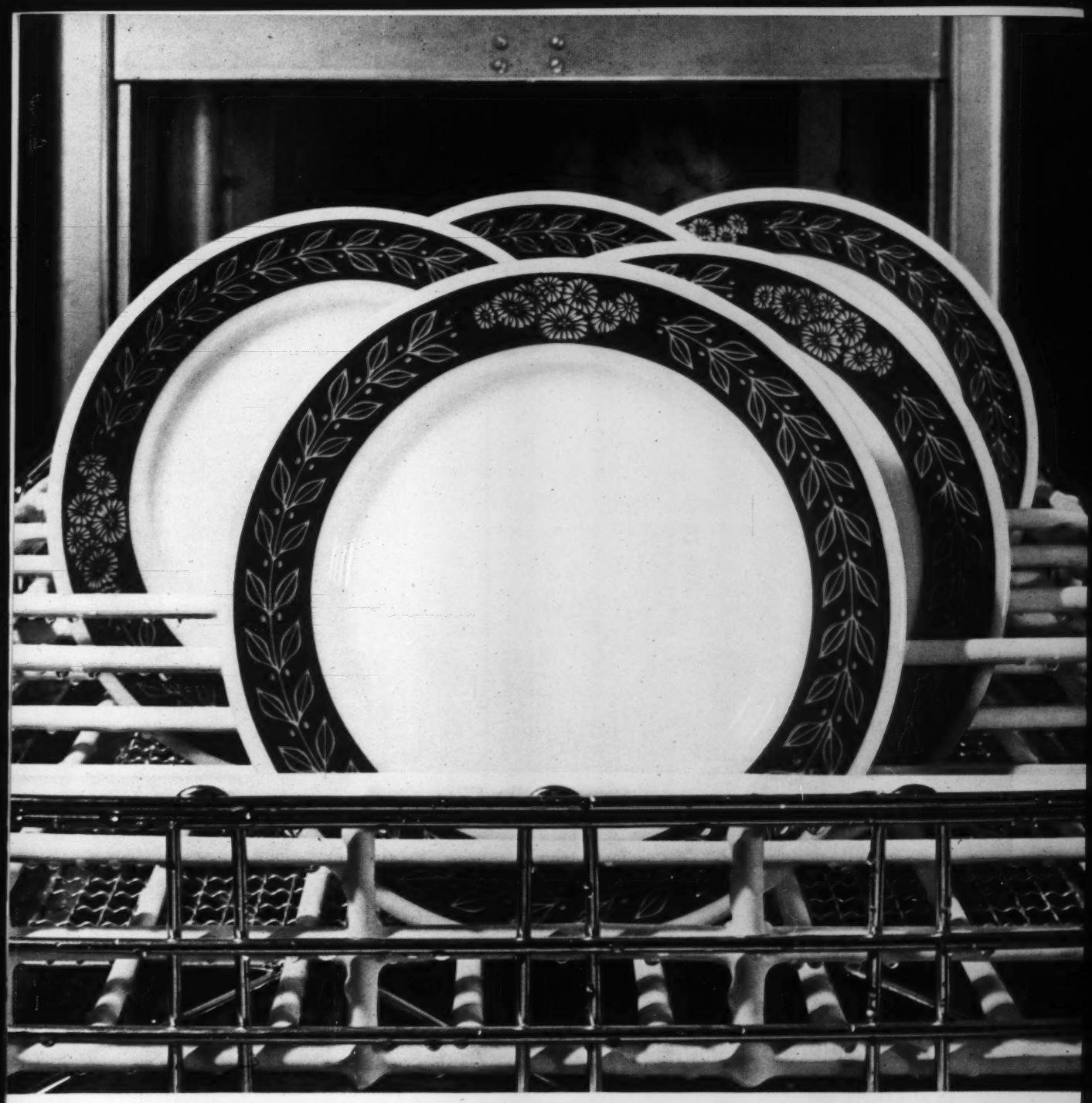
Believing that what one sees can greatly influence one's appetite, the staff at Allegheny General Hospital, Pittsburgh, Pa., designed its new pay cafeteria for employees and staff with a decor and equipment that would enhance the merchandising of the food served.

THE BELIEF that the eyes have a great influence upon appetite was given considerable attention in the planning of the new pay cafeteria for personnel and staff at the 578-bed Allegheny General Hospital, Pittsburgh, Pa. Opened

(Continued on page 85)

Ruth Silvester is director of dietetics at Allegheny General Hospital, Pittsburgh, Pa.

REFRIGERATED, revolving salad serving unit is incorporated into the cafeteria counter at Allegheny General Hospital, Pittsburgh, Pa. Displayed on a bed of crushed ice, even the simplest salad gains in customer appeal. Note the accessibility of refrigeration units for storage of salads.



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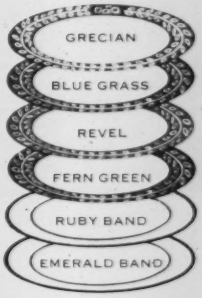
Results of breakage tests conducted by York Research Corp.

CORNING *Decor* **DINNERWARE**



Oatmeal makes the patient feel "at home"

Naturally nutritious oatmeal is high in protein... high in thiamine

Quaker Oats and Mother's Oats are the same fine product.

Oatmeal is an ideal food for hospitalized patients, providing more protein than any other whole-grain cereal. Oatmeal with milk contributes substantially to the dietary allowances recommended for thiamine, riboflavin, niacin and iron. Rich in phosphorus, low in sodium, it is unsurpassed in dietary usefulness.

Oatmeal is easy to prepare . . . and economical to serve. It's high in nourishment . . . low in calories, even with milk.

One ounce of Quaker Oats provides the following percentages of adult M.D.R.: thiamine (vitamin B_1) 16.5%, phosphorus 16.5%, and iron 11.0%. Each ounce also provides 110 calories, and 16.7% protein, 6.9% fat, 62.4% carbohydrates, and 1.5% non-nutritive crude fiber.

For additional information write: Medical Service Dept.

The Quaker Oats Company
CHICAGO 54, ILLINOIS

in 1960, the new cafeteria located on the third floor of the hospital serves between 1700 and 2000 employees, staff, student nurses and visitors each day. The new facility, which has a seating capacity of 400, replaces the nonpay cafeteria and seven separate dining rooms located throughout the hospital for employee and staff feeding. With elimination of these feeding facilities, the hospital has been able to reclaim 45,000 sq. feet for other clinical and paramedical services including a new cardio-pulmonary laboratory, cleft palate and oral surgery clinic, and central supply area.

This belief that one first eats with his eyes prompted the hospital to choose equipment and a decor for the cafeteria that would lend a pleasing framework for the service of well prepared attractively-served food. An all-glass divider separates the cafeteria counter from the entrance hallway and gives cafeteria patrons a full view of the 90-foot stainless steel serving counter and a glimpse of the dining room beyond (see photo above). The color scheme for the dining facilities is repeated in the mosaic tile wall behind the serving counter; the colors being pale yellow, nutmeg, white and black.

Through variations in ceiling heights, coved lighting and dividers, the dinings area appears to be three separate rooms. The western section, through the use of folding doors, may be divided into six separate dining rooms for special luncheons and meetings (see photo, page 82). One of these dining rooms is allocated to the medical staff for its use if the physicians so desire.

SALAD MERCHANDISING

The star attraction featured in the cafeteria line is the revolving, refrigerated "lazy susan" for salad service (see photo, page 82). During the building program, this piece of equipment aroused a great deal of speculation as to its purpose and many fanciful rumors have spread about it. It is well known that crisp, colorful salads have great appeal for the customer. Moreover, even the relatively plain salad becomes glamorous when it is displayed upon a sparkling bed of flaked ice.

THE 90-FOOT long stainless steel cafeteria counter at Allegheny General Hospital, Pittsburgh, Pa., is separated from the dining area and corridor by a transparent glass divider.

Salad ingredients are sent to the cafeteria from the pre-preparation area on the first floor and the salads are assembled in the work unit and stored in the salad refrigerator. The work and refrigerator units are located on the third floor directly behind the "lazy susan" section of the cafeteria counter.

The revolving salad server is also useful for merchandising other menu items. The hospital now sells three times more cold plates than it did when they were displayed on the regular cold counter of the cafeteria.

EFFECTS OF NEW EQUIPMENT

The roll warmer on-the-counter and the built-in refrigerated butter dispenser are two other pieces of equipment that have resulted in increased cafeteria sales. Better sales because of better preparation have also been made possible by the installation and use of on-the-counter steamers for vegetable preparation, electronic oven for entrees and vegetables, reach-in refrigerators with mobile shelving, and rotary ovens. Two small steamers (7½ qts.) make it possible to provide on-the-counter cooking of vegetables. Fresh vegetables are prepared in the pre-preparation unit and the frozen vegetables are stored in the freezers located on the cafeteria line near the steamers.

The electronic oven, which is placed next to the vegetable cooking units, has also been a focal point of interest for employees as well as an effective tool for improved preparation and serving methods for certain items. This unit may be used in a number of ways. Although the hospital has used it for roasting beef (cooking time 45 minutes), the oven has proved to be of greater value in the preparation of portion-size cuts of meat, fish and poultry. Chops, steaks and fish fillets, preseared for eye appeal before freezing, cook in an unbelievably short time (between 25-35 seconds).

The electronic oven is also used for preparation of extra orders of baked potatoes. Cooking time for eight potatoes is 6 minutes. The electronic oven is also used to reconstitute already prepared food for patients' trays which have been delayed.

With the exception of freezers and walk-in refrigerators, all refrigeration units are equipped with roll-out shelves. This feature permits great flexibility in handling, transportation and storage of foods. Mobile shelving makes it possible to pre-portion baked goods, puddings, etc., before rolling the carrier loaded with serving dishes to the refrigerator unit for storage in the serving areas, where it will be readily available at service time.

Roasts, casseroles and other baked entrees for service in the cafeteria are prepared in the main

Breakfast

Half Grapefruit
Orange Juice
Oatmeal
Choice of Dry Cereals
Scrambled Eggs
Sweet Rolls — Toast
Jelly
Coffee — Tea — Milk
Hot Chocolate — Sanka

Luncheon

Vegetable Soup
Orange Juice
Breaded Veal Cutlet, Tomato Sauce
Corn Fritters, Maple Syrup
Grilled Hamburger on Bun
Fresh Green Beans
Waldorfian Salad
Head Lettuce, Russian Dressing
Garden Salad
Jewel Crowned Grape Salad
Lemon Meringue Pie
Ice Cream — Sherbet
Coffee — Tea — Milk — Sanka
Iced Tea — Hot Chocolate

Dinner

Vegetable Soup
Orange Juice
Pot Roast of Beef, Gravy
Broiled Fresh Halibut Steak
Brunschweiger Sandwich
Lyonnaise Potatoes
Fresh Peas
Mashed Hubbard Squash
Tossed Vegetable Salad
Jellied Cherry Salad
Celery, Olives
Ice Cream Cake Roll
Fresh Tangerine
Coffee — Tea — Milk — Sanka
Iced Tea — Hot Chocolate

Sample menu used in cafeteria at Allegheny General Hospital

kitchen. The rotary ovens have fascinated the cooks. The rotating ovens have also eliminated the employee bending over and lifting heavy pans. Thus the cooks' workload has been made easier, safer and more efficient. Moreover, by careful planning, a variety of products may be prepared at the same time in these ovens.

PAYMENT FOR MEALS

Before the new cafeteria was opened, all personnel received at least one meal as a fringe benefit. Since the new facilities called for a pay cafeteria, a salary adjustment was indicated. It was decided to reimburse the employee for the meal or meals that he would have received during his hours on the job. An analysis was made of raw food cost per meal served, and this became the basis upon which the salary adjustment was made. All hospital personnel and staff with the exception of dietary department employees, student nurses and student technicians, now purchase their meals in the cafeteria.

Dietary employees, student nurses and technicians are issued books of tickets in denominations of 1, 5, 10, 25 and 50 cents. These books are issued once a month and are coded so that the tickets left-over may not be used the following month. The value of the script books was formulated upon the same basis as that used in determining the amount of money given in the salary adjustment.

SERVICE HOURS

The cafeteria is open for service at the following hours:

Breakfast	**6:15 - 9 a.m.**
Coffee break	**9:30 - 10:30 a.m.**
Lunch	**10:30 a.m. - 1:30 p.m.**
Coffee break	**2 - 3:30 p.m.**
Dinner	**3:30 - 6:45 p.m.**
Midnight supper	**10 - 12 a.m.**

We have been surprised and pleased by the number of employees and staff other than those entitled to this meal who come to breakfast. Their comment: "It is worth it. It sets me up for the day." They also thoroughly enjoy their coffee breaks. When it was discovered that the tray girls found the coffee break too relaxing, their supervisors were given the same time for a break. The supervisors now bring their groups back to the job on time.

TYPE OF MENU

Cafeteria patrons enjoy the menu choice now made possible by the new facility. Each day's menu for breakfast includes a choice of fruits or fruit juices; cooked or dry cereals; eggs; rolls; and other items such as french toast, bacon, pancakes, sausages and a choice of beverages.

The luncheon menu offers a choice of entrees (hamburgers, wieners and combination sandwiches are favorites); meats; casseroles; sandwiches; a wide selection of salads (gelatin salads are extremely popular); vegetables; choice of desserts and beverages.

The dinner menu offers a choice

SERVING PERIOD	NUMBER AND TYPE OF EMPLOYEES
Breakfast	**5 counter women**
Coffee Break	
Lunch	**15 counter women, 2 bus girls, 1 bus boy, 1 porter, 1 part-time short-order cook**
Coffee Break	
Dinner	**13 counter women, 1 part-time short-order cook if needed**
Midnight Supper	**2 counter women (they also wash dishes, care for receiving room, etc.)**

of roast (pork is most popular) or poultry; sandwiches and perhaps an omelet, cold plate, etc.; potatoes; vegetables; choice of salads, desserts and beverages.

By popular request, orange juice and hot chocolate are available during all meal hours as well as during coffee breaks. Iced tea is an extremely popular item and since the new facilities make it possible to include this item on the daily menu, it is now offered the year around.

The prices charged in the cafeteria are based on raw food cost only.

Prior to the opening of the cafeteria, employees and staff expressed some concern over whether or not they could afford the meals in the new cafeteria. They were pleasantly surprised by the low prices (raw food cost) although there have been a few persons who prefer to carry their lunches and to buy a beverage, salad, or dessert.

STAFFING THE CAFETERIA

The number and types of employees required to staff the cafeteria during service hours are shown in table on facing page.

As time goes on, the dietary department hopes to acquire a better knowledge of the use of the new equipment and of customer preferences, so that it might do a better job and win even more favorable comments from cafeteria patrons. ■

NOTES AND COMMENT

Oregon hospital lists menu favorites

Menu favorites with patients at Good Samaritan Hospital in Portland, Ore., include seafood casserole, oven baked turkey sandwich with special sauce and golden apricot molds, reports Olga Wasylyk, the hospital's chief dietitian. Miss Wasylyk has included these menu items on her set of spring cycle menus for the North-Northwest, beginning on p. 91.

Here are the recipes for these menu items:

SEAFOOD CASSEROLE
(100 servings)

5 lbs. shrimp
5 lbs. crab meat
5 lbs. scallops
2 gal. medium white sauce
Salt and pepper to taste
50 slices toast, cubed
3½ lbs. sharp cheese, grated

1. Clean shrimps and remove shell from crab meat.
2. Sauté shrimps, crab meat and scallops lightly in the fat which is to be used for the white sauce.
3. Make medium white sauce and add to sea food.
4. Season to taste.
5. Into each 6 oz. casserole, place ½ slice toast (cubed) and ½ cup sea food mixture. Cover with layer of grated cheese.
6. Put casseroles under broiler until cheese is delicately browned and mixture is hot.

OVEN BAKED TURKEY SANDWICH WITH SPECIAL SAUCE
(100 servings)

10 lbs. turkey, cooked and sliced
3 lbs. butter or margarine
100 slices sandwich bread
1 lb. butter or margarine, melted
4½ lbs. canned mushroom pieces, drained
6 qts. special sauce
2 lbs. sharp cheddar cheese, shredded

(Continued on page 88)

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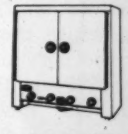
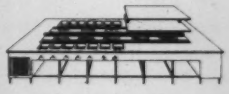

PELLET OVEN

PELLET OVEN STAND

TRAY CART


TRAY ASSEMBLY TABLE

DRI-HEAT FOOD SYSTEM

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Chicago, Illinois

1. Whip 3 lbs. butter and spread one side of bread slices.

2. Butter generously 8 jelly roll pans (10 x 15½ inches). Place bread, buttered side up, in pans.

3. Toast top sides of bread in broiler until golden brown.

4. Place slices of turkey on bread. Brush with melted butter. Top with mushrooms.

5. Pour special sauce over each sandwich, using approximately 6 c. sauce for every pan. Sprinkle cheese over all.

6. Bake sandwiches in 350° F. oven for 15 minutes.

Special Sauce
(6 qts.)

1 c. onions, chopped
⅔ c. green peppers, chopped
2 c. butter or margarine
1⅓ c. flour
2 tbsp. salt
⅔ c. pimento, chopped
5 qts. hot milk
10 eggs, beaten

1. Pan fry onions and green peppers in butter. Add flour. Stir until bubbly. Add salt, pimento and hot milk. Cook, stirring constantly, until mixture boils. Cook 5 minutes.

2. Add small amount of hot sauce to beaten eggs. Add egg mixture to sauce gradually. Stir. Cook 10 minutes. The sauce should be fluffy.

GOLDEN APRICOT MOLDS
(120 servings)

3½ qts. canned apricot juice
1 qt. vinegar
2 lbs. sugar
1 oz. whole cloves
4½ qts. peeled apricots
1 stick cinnamon
2 pkg. orange flavored gelatin
3 qts. water

1. Combine apricot juice, vinegar, sugar, cloves and cinnamon and bring to boil.

2. Add apricots and simmer 10 minutes.

3. Remove apricots.

4. Strain syrup and add water to make 2 gal. liquid. Dissolve gelatin in liquid; chill.

5. When gelatin mixture is slightly thickened, add apricots.

6. Pour mixture into 5 pans (12 x 20 x 2½ inches) and refrigerate until set.

7. Cut 24 salads per pan.

8. Serve on lettuce and garnish with cranberry sauce. ■

Spring Cycle Menu for the North-Northwest

THE 21-DAY selective spring cycle menu and market orders for perishables are designed particularly for hospitals in the northern and northwestern sections of the United States. These menus, which may be used during March, April and May, feature foods popular in these sections of the country.

The menus in this issue are the final set in the four-part series of spring cycle menus published in this Journal. Spring cycle menus for Midwest hospitals were included in the January 1 HOSPITALS, J.A.H.A. The South-Southwest spring cycle menus were published in the January 16 issue of the Journal. The East menus were included in the February 1 issue.

In planning the menus, careful consideration has been given to keeping the menu and food production operation simple for the smaller hospital. Moreover, a moderate to low-cost food budget was used.

This cycle menu features a choice of entree, vegetable, salad and dessert on the noon and night menus. Two cereals and two fruits are offered on the breakfast menu.

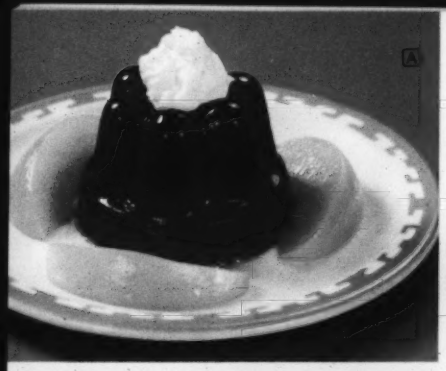
Since one of the choices offered is designed for use on modified diets, these menus can be used for both normal and modified diets. The letter (F) following certain items on the menu indicates that this item is to be served on the full or normal diets, while those labeled (S) are for the soft and other modified diets. Where the letters (FS) appear, the menu item can be served on both the full and soft diets.

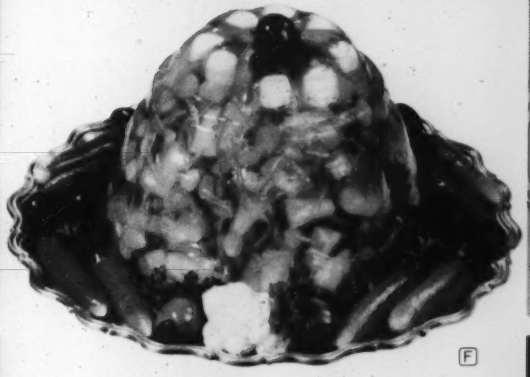
The winter cycle menus, published in the October and November 1960 issues of this Journal, may be used during February. The Midwest and South-Southwest cycle menus appeared in the October 1 and 16 issues, respectively. The November 1 and 16 issues featured cycle menus for the East and North-Northwest, respectively.

The market order for perishables, which accompanies each week's menu, lists the meats, seafood, poultry, and fresh and frozen fruits and vegetables that a 50-bed hospital will need to produce the menu. The market order includes all portion-ready meats, oven-ready roasts, portion-ready seafood, eviscerated poultry and other pre-prepared items. The amounts are computed on the basis of serving 100 patients and personnel meals at breakfast, 125 at noon and 100 at night. By using a multiple of 50, larger hospitals can easily arrive at their market orders.

An added feature of this menu service is the standard storeroom inventory, a list of supplies that a 50-bed hospital should have in the storeroom at the beginning of each 21-day cycle. The items included are cereals and farinaceous products, canned fish, canned fruits and fruit juices, dried fruits and vegetables, jellies, cake and pudding mixes, pickles, canned soups and canned vegetables.

The standard is available upon request by writing the American Hospital Association, 840 North Lake Shore Drive, Chicago 11, Ill.



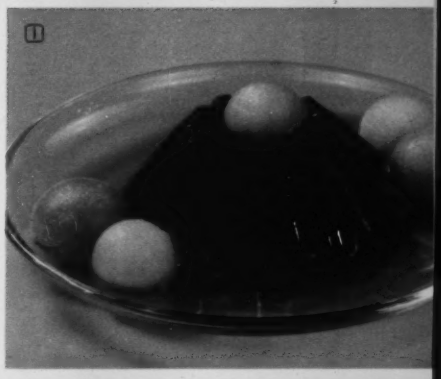


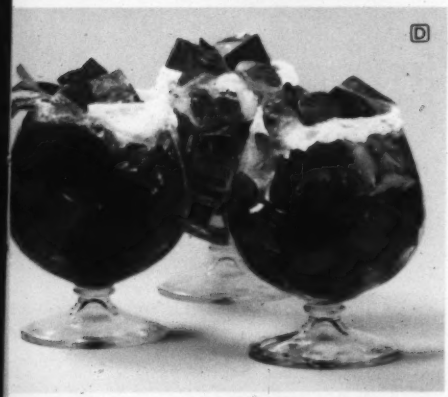
11 ideas for serving colorful, delicious

Sexton Gelatines

Sexton gelatines have captured nature's own fresh-fruit taste in a wide variety of palate-pleasing, eye-appealing flavors. Delicious for salads or desserts, they take only minutes to make and cost only pennies per serving. They will stand up for hours, remaining firm in form, clear in color and fresh in flavor. And because they are low in calories, salt free* and with vitamin C added, Sexton gelatines have particular appeal to the diet-conscious.

**Except Black Raspberry*





A Melba gelatine garnished with Sexton peach slices. B Citrus gelatine with lettuce and sections of Sexton grapefruit and mandarin orange. C Wild Cherry gelatine with Sexton mayonnaise and nut topping; bordered by endive and Sexton kumquats. D Sexton 5-flavor gelatine melange, with cubes of orange, lime, black raspberry, lemon and wild cherry. E Apple gelatine with grapes. F Buffet salad of Lemon gelatine molded with Sexton pineapple tidbits and marshmallows, white raisins and shredded carrots; bordered by Sexton tiny whole carrots, stuffed olives, cauliflower and rosebud beets. G Red Raspberry gelatine topped with whipped cream and decorettes. H Lime gelatine enclosing shredded cabbage, Sexton pimientos and green peppers; garnished with a radish rose, endive and pecan-capped cheese ball. I Black Raspberry gelatine with melon balls. J Orange gelatine bordered by water cress, avocado slices, cream cheese ball with grated nuts and Sexton Royal Anne cherries. K Strawberry gelatine with marshmallow and strawberry slices within; decorated with whipped cream and a halved fresh strawberry.

China shown is McNicol, distributed by Sexton.

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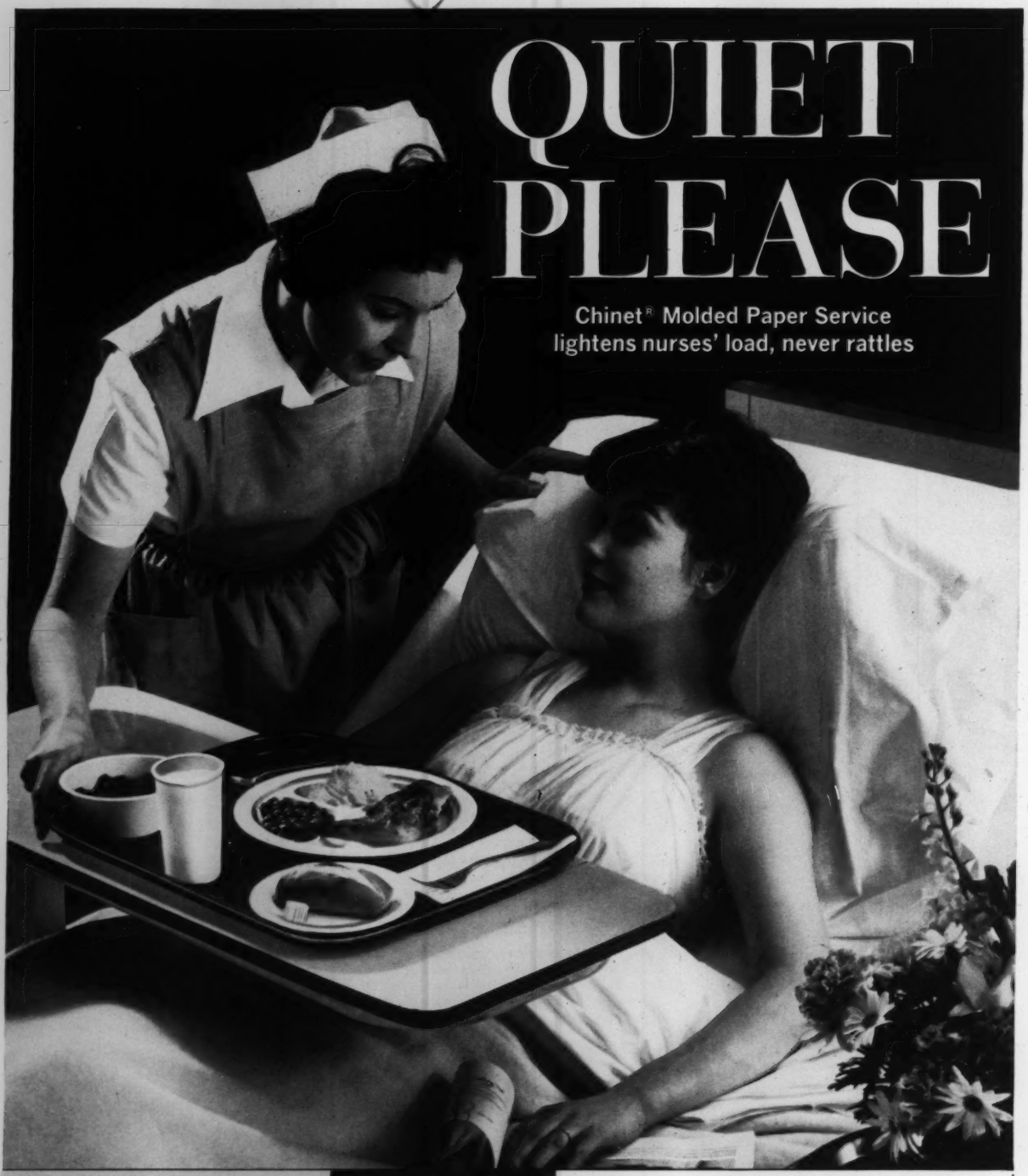

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1st WEEK NORTH-NORTHWEST SELECTIVE SPRING CYCLE MENU

(MENUS TO BE USED DURING MARCH, APRIL AND MAY)

—prepared by Olga Wasylyk, director of dietetics, Good Samaritan Hospital, Portland, Ore.

	breakfast	noon	night
monday	Apple Juice (S) **or** Half of Grapefruit (F) Farina **or** Shredded Wheat Cereal Scrambled Egg with Link Sausage Toast with Jelly	Beef and Vegetable Soup with Saltines Chicken Pot Pie (FS) **or** Round Steak Roll-up with Gravy Buttered Cauliflower with Parsley **or** Buttered Spinach (FS) Shredded Lettuce and Grated Egg Salad with French Dressing **or** Spiced Peach Salad with Mayonnaise Peppermint Candy Ice Cream (FS) **or** Fresh Fruit Cup	Cream of Mushroom Soup with Wheat Thins Pot Roast of Beef with Vegetable Gravy (S) **or** Broiled Ham Steak with Pineapple Slice (F) Country Fried Potatoes (F) **or** Parsleyed Potatoes (S) Buttered Brussels Sprouts **or** Buttered Carrots (FS) Ambrosia Fruit Salad **or** Stuffed Celery Chilled Bing Cherries in Syrup (S) **or** Burnt Sugar Cupcake with Mocha Frosting (F)
tuesday	Orange Juice (FS) **or** Stewed Fruit Compote Cooked Whole Wheat Cereal **or** Cornflakes Scrambled Eggs Hot Walnut Muffins (F)	Grape Juice Cocktail Italian Spaghetti (F) **or** Sautéed Liver with Bacon (S) Baked Potato (S) Buttered Mixed Vegetables **or** Buttered Asparagus (FS) Molded Pear Jade Salad with Mayonnaise **or** Tossed Greens with Vinegar and Oil Dressing Frosted Chocolate Brownies (F) **or** Glazed Baked Apple with Cream (S)	Chicken Broth with Thimble Dumplings Veal Birds with Mushroom Sauce (FS) **or** Hot Crabmeat on Toast Points Baked Potato with Whipped Butter (FS) Buttered Whole Kernel Corn **or** Buttered Green Beans (FS) with Almonds (F) Raw Relishes with Dip **or** Peeled Apricot Flower Salad with Fruit Dressing Pineapple Sherbet (FS) **or** Chilled Plums in Syrup
wednesday	Tomato Juice (S) **or** Stewed Rhubarb (F) Farina **or** Ready-to-Eat Malt Flake Cereal Poached Egg and Crisp Bacon Toast with Jelly	Oxtail Soup with Oyster Crackers Hot Roast Beef Sandwich (FS) **or** Sweet and Sour Spareribs Buttered Cabbage Wedge **or** Buttered Peas (FS) Combination Vegetable Salad with Blue Cheese Dressing **or** Fresh Fruit Salad with Fruit Dressing Williamsburg Orange-Wine Cake (F) **or** Chilled Peaches in Syrup (S)	Cranberry Juice Roast Turkey with Dressing and Giblet Gravy (FS) **or** Mixed Grill Whipped Potatoes (FS) Broccoli **or** Baked Acorn Squash with Brown Sugar (FS) Waldorf Salad (F) **or** Lettuce Wedge with Russian Dressing Chocolate Ice Cream (FS) **or** Grapes
thursday	Grapefruit Juice (F) **or** Banana (S) Oatmeal **or** Puffed Wheat Cereal Soft Cooked Egg Cinnamon Toast	Cream of Celery Soup with Triscuits Beef Stew with Whole Vegetables (F) **or** Welsh Rarebit on Toast with Crisp Bacon (S) Buttered Cauliflower **or** Buttered Beets (FS) Green and Gold Fruit Salad with Fruit Dressing **or** Garden Greens with Green Goddess Dressing Baked Custard (FS) **or** Chilled Kadota Figs in Syrup	French Onion Soup with Cheese Croutons Braised Round Steak with Fresh Mushrooms (FS) **or** Roast Loin of Pork with Hot Cranberry Sauce Hash Browned Potatoes (F) **or** Whipped Potatoes (S) Buttered Succotash **or** Buttered Spinach with Grated Hard-Boiled Egg (FS) Sliced Tomato Salad with French Dressing **or** Frosty Peach and Pear Salad with Mayonnaise Lemon Pie (F) **or** Chilled Whole Peeled Apricots in Syrup (S)
friday	Prune Juice (S) **or** Orange Slices (F) Farina **or** Bran Flake Cereal Fried Egg Danish Pastry	Southern Seafood Gumbo with Saltines Baked Tuna-Noodle Casserole (FS) **or** Frosted Meat Loaf Stewed Tomatoes **or** Buttered Carrot Pennies with Parsley (FS) Molded Perfection Salad with Mayonnaise **or** Fruit Tidbit Salad with Honey Cream Dressing Coffee Ice Cream (FS) **or** Chilled Royal Anne Cherries in Syrup	Vegetarian Vegetable Soup with Assorted Crackers Sesame Chicken Breast with Hollandaise Sauce (F) **or** Stuffed Fillet of Sole with Tartar Sauce (S) Baked Potato with Sour Cream (FS) Buttered Broccoli (F) **or** Buttered Green Beans Julienne (S) Confetti-Cottage Cheese Salad with Mayonnaise **or** Grapefruit and Avocado Salad with Fruit Dressing Angel Food Cake with Strawberry Glaze (FS) **or** Fresh Pineapple
saturday	Pineapple Juice **or** Applesauce (FS) Rolled Wheat Cereal with Brown Sugar **or** Ready-to-Eat Rice Cereal French Toast with Syrup	Blended Fruit Juice Veal Fricassee on Cornbread (FS) **or** Buttered Sauteed Chicken Livers on Toast Points Baked Stuffed Onions **or** Buttered Asparagus with Pimento (FS) Pear, Prune and Nut Salad with Fruit Dressing (F) **or** Marinated Vegetable Salad Raspberry Sherbet (F) **or** Chilled Peaches in Syrup (S)	Cream of Tomato Soup with Oyster Crackers Pot Roast of Beef with Gravy (FS) **or** Breaded Pork Chop with Country Gravy Oven Browned Potato (FS) Buttered Brussels Sprouts **or** Steamed Hubbard Squash with Butter (FS) Cole Slaw **or** Citrus Salad with Honey French Dressing Boston Cream Pie (F) **or** Chilled Pears in Syrup (S)
sunday	Orange Juice (FS) **or** Stewed Prunes with Lemon Rice Farina **or** Wheat Flake Cereal Poached Egg with Crisp Bacon Toast with Jelly	Fruit Cup (FS) Roast Turkey (FS) with Dressing and Giblet Gravy (F) **or** Roast Leg of Lamb with Mint Sauce Whipped Potatoes (FS) Buttered Whole Kernel Corn **or** Buttered Beets (FS) Pineapple-Cottage Cheese Salad **or** Raw Relishes Ice-Box Cake (FS) **or** Fresh Pear	Cream of Vegetable Soup with Blue Cheese Crackers Baked Beef Pie (FS) **or** Meat Drumstick with Cream Gravy Buttered Mixed Vegetables **or** Buttered Peas with Mushrooms (FS) Crunchy Fresh Vegetable Salad with French Dressing **or** Molded Fruit Salad with Mayonnaise and Lemon Juice Banana-Nut Ice Cream (F) **or** Chilled Whole Peeled Apricots in Syrup (S)

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

1st week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Ground Beef	U. S. Good, 5 lb. pkg.	45 lbs.	
Liver	Steer, sliced	10 lbs.	40
Roast, Sirloin (B.R.T.)	U. S. Choice	27 lbs.	80
Round (Top, Boneless)	U. S. Good	40 lbs.	120
Steaks, Round	U. S. Choice, 4 oz. each	25 lbs.	100
Stew	U. S. Good	25 lbs.	100
LAMB			
Chops, Loin	U. S. Choice, 6 oz. each	8 lbs.	20
Leg (B.R.T.)	U. S. Choice, yearling	13 lbs.	40
PORK			
Bacon (Sliced)	24-26-1 lb.	12 lbs.	
Chops, Loin	Grade A, 4 oz. each	5 lbs.	20
Ham (Pullman)	Ready-to-eat	7 lbs.	20
Loin (Boneless)	Grade A, 10-12 lbs.	7 lbs.	20
Spareribs	Grade A, 3-1 lb.	20 lbs.	40
VEAL			
Leg (B.R.T.)	U. S. Good	20 lbs.	60
Shoulder (Boneless)	U. S. Good	25 lbs.	100
FISH			
Sole	Frozen, fillets	5 lbs.	20
POULTRY			
Breast, Chicken	6 oz. each	23 lbs.	60
Fowl (Eviscerated)	Grade A, 5 lb. av.	75 lbs.	
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	105 lbs.	140
Livers, Chicken	1 lb. pkg.	8 lbs.	40
FRESH FRUITS			
Apples	Jonathan, 113s	1 box	
Avocado	Ripe	½ doz.	
Bananas	Ripe	30 lbs.	
Grapefruit	Seedless, 70s	½ box	
Grapes	Seedless	5 lbs.	
Lemons		1 doz.	
Oranges	176s	½ box	
Pears		13 lbs.	
FRESH VEGETABLES			
Cabbage		15 lbs.	
Carrots	Topped, bag	50 lbs.	
Celery	Pascal, 30s	1 doz.	
Celery	White	1½ doz.	
Endive	Curly	1 doz.	
Lettuce	Head, 48s	1 crate	
Onions, Dry	Yellow, bag	50 lbs.	
Onions, Green	Bunch	1 doz.	
Parsley	Bunch	1 doz.	
Potatoes, White	Bag No. 1	300 lbs.	
Radishes	Bunch	1 doz.	
Romaine		1 doz.	
Squash, Acorn		30 lbs.	60
Tomatoes		7 lbs.	
Watercress	Bunch	1½ doz.	
FROZEN FRUITS			
Grapefruit Sections	Fresh, chilled, gallon	1 gal.	
Orange Juice	Con., 32 oz. can	6 cans	
Orange and Grapefruit Sections	Fresh, chilled, gallon	3 gal.	
Peaches	Sliced, 8 lb. can, 5-1 sugar	8 lbs.	
Pineapple	Fresh, chilled, gallon	1 gal.	
Plums	8 lb. can, 5-1 sugar	8 lbs.	
Rhubarb	8 lb. can, 5-1 sugar	8 lbs.	
FROZEN VEGETABLES			
Asparagus	Spears, 2½ lb. pkg.	30 lbs.	180
Beans, Green	Julienne, 2½ lb. pkg.	12½ lbs.	75
Broccoli	Stems and buds 2½ lb. pkg.	12½ lbs.	75
Brussels Sprouts	2½ lb. pkg.	5 lbs.	30
Cauliflower	Buds, 2½ lb. pkg.	5 lbs.	30
Peas	2½ lb. pkg.	25 lbs.	150
Spinach	Chopped, 2½ lb pkg.	25 lbs.	150
Squash, Winter	3 lb. pkg.	15 lbs.	60
Succotash	2½ lb. pkg.	2½ lbs.	15
Vegetables, Mixed	2½ lb. pkg.	5 lbs.	30

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2nd WEEK NORTH-NORTHWEST SELECTIVE SPRING CYCLE MENU

(MENUS TO BE USED DURING MARCH, APRIL AND MAY)

—prepared by Olga Wasylyk, director of dietetics, Good Samaritan Hospital, Portland, Ore.

	breakfast	noon	night
monday	Grapefruit Juice (S) **or** Baked Apple with Cream (F) Oatmeal with Dates (F) **or** Cornflakes Scrambled Eggs Hot Muffin with Marmalade	Cream of Asparagus Soup with Croutons Hot Roast Beef on Bun **or** Macaroni and Cheese (FS) Buttered Broccoli **or** Buttered Green Beans (FS) Lettuce Wedge with 1000 Island Dressing **or** Red and White Cherry Salad with Honey Cream Dressing Lemon Bread Pudding with Meringue (F) **or** Chilled Peeled Plums in Syrup (S)	Navy Bean Soup with Saltines Breaded Veal Cutlet with Fresh Mushroom Sauce (FS) **or** Corned Beef — New England Style Parsleyed Buttered Potatoes (FS) Buttered Cabbage Wedge **or** Buttered Carrots (FS) Chef's Salad with French Dressing **or** Frozen Fruit Salad Chocolate Sundae (FS) **or** Grapes
tuesday	Prune Juice (S) **or** Orange Sections (F) Farina **or** Shredded Wheat Cereal Soft Cooked Eggs and Link Sausages Toast and Butter	Consomme with Triscuits Creamed Chipped Beef on Biscuits (FS) **or** Sliced Ham and Potato Salad Escalloped Tomatoes **or** Buttered Spinach with Lemon (FS) Molded Cranberry Salad with Mayonnaise **or** Pickles and Olives Assorted Cookies **or** Canned Fruit Cup (FS)	Blended Fruit Juice Oven Fried Chicken with Giblet Gravy (F) **or** Roast Leg of Lamb with Mint Jelly (S) Rice Pilaf (FS) Buttered Whole Kernel Corn **or** Buttered Asparagus (FS) Peach Gels on Endive with Mayonnaise **or** Wilted Lettuce Salad Pineapple Upside-down Cake with Whipped Cream (F) **or** Chilled Pears in Syrup (S)
wednesday	Pineapple Juice (F) **or** Banana (S) Cooked Whole-wheat Cereal **or** Puffed Rice Cereal Poached Egg Cinnamon Toast	Cream of Potato Soup with Assorted Crackers Salisbury Steak with Mushroom Gravy (FS) **or** Hot Sliced Tongue with Raisin Sauce Buttered Brussels Sprouts **or** Buttered Beets (FS) Canned Fruit Salad with Honey Cream Dressing (F) **or** Avocado Salad Bowl with French Dressing Blancmange (FS) **or** Frozen Strawberries	Jellied Consomme with Saltines Pot Roast of Beef with Vegetable Gravy (FS) **or** Oven Fried Perch Dipped in Cornmeal with Tartar Sauce French Fried Potatoes (F) Buttered Cauliflower **or** Baked Acorn Squash (FS) Stuffed Celery **or** Golden Apricot Mold with Sour Cream-Fruit Dressing Apple Pie (F) **or** Vanilla Ice Cream (S)
thursday	Orange Juice (S) **or** Stewed Rhubarb (F) Rice Farina **or** Bran Flake Cereal Jelly Omelet with Toast	Blended Vegetable Juice with Saltines Oven Baked Turkey Sandwich (FS) **or** Lamb Curry on Rice Buttered Mixed Vegetables **or** Buttered Green Beans (FS) Pear-Waldorf Salad **or** Tomato Aspic with Mayonnaise Pineapple Sherbet **or** Royal Anne Cherries in Syrup (FS)	Vegetable Soup with Wheat Thins Stuffed Flank Steak with Gravy (FS) **or** Butter Browned Sweetbreads with Wine Sauce Whipped Potatoes (FS) Creamed Tiny Onions **or** Buttered Peas (FS) Lettuce Wedge with Blue Cheese Dressing **or** Fruit Tidbit Salad with Fruit Dressing Almond Torte (F) **or** Chilled Peeled Plums in Syrup (S)
friday	Grapefruit Juice (FS) **or** Stewed Prunes with Lemon Rolled Wheat Cereal **or** Cornflakes Soft Cooked Egg Pecan Rolls (F)	Oyster Stew with Oyster Crackers Braised Tenderloin Tips with Noodles (FS) **or** Crab Louie with Potato Chips Baked Stuffed Mushrooms **or** Buttered Carrots with Parsley (FS) Fruit-Cottage Cheese Bowl with Mayonnaise **or** Crunchy Fresh Vegetable Salad with Fruit Dressing Chocolate Cake with Chocolate Frosting (FS) **or** Grapes	Pear Nectar Broiled Salmon Steak with Lemon Butter (FS) **or** Roast Leg of Veal with Brown Gravy Baked Potato with Whipped Butter (FS) Buttered Baby Limas **or** Buttered Spinach (FS) Fresh Pineapple on Endive with Honey Cream Dressing **or** Pickles and Olives Lemon Custard Ice Cream **or** Whole Peeled Apricots in Syrup (FS)
saturday	Apple Juice (S) **or** Chilled Sliced Pineapple (F) Farina **or** Ready-to-Eat Wheat Flake Cereal Fried Egg Toast with Assorted Jellies	Turkey-Noodle Soup with Saltines Barbecued Pork on Bun (F) **or** Swiss Cheese Fondue (S) Buttered Mixed Vegetables **or** Buttered Asparagus (FS) Mixed Greens with 1000 Island Dressing **or** Stuffed Apricot Salad with Sweet French Dressing Tapioca Cream Pudding (FS) **or** Fresh Fruit Cup	Grape-Gingerale Punch Beef Roll-ups with Gravy (FS) **or** Baked Ham with Spiced Cherry Sauce Country Fried Potatoes (F) **or** Buttered Rice (S) Buttered Whole Kernel Corn **or** Buttered Beets (FS) Marinated Vegetable Salad **or** Ambrosia Salad with Honey Cream Dressing Banana Cream Pie (F) **or** Fruit Cocktail in Syrup (S)
sunday	Tomato Juice (FS) **or** Kadota Figs Oatmeal **or** Ready-to-Eat Rice Cereal Scrambled Eggs with Pieces of Ham Cinnamon Coffee Cake	Cranberry-Lime Sherbet Oven Baked Chicken Breasts with Fricassed Gravy (FS) **or** Grilled Veal Chop with Sour Cream Gravy Candied Sweet Potatoes (FS) Buttered Cauliflower Polonaise **or** Buttered Peas (FS) Cole Slaw with Celery Seed Dressing **or** 24-Hour Fruit Salad Sponge Cake (F) **or** Baked Apple (S)	Vegetable Bisque with Saltines Beef-Rice Balls with Mushrooms (FS) **or** Savory Egg Casserole Buttered Broccoli **or** Buttered Green Beans Julienne (FS) Raw Relishes with Dip **or** Pear-Jelly Salad with Mayonnaise Rainbow Gelatin (FS) **or** Boysenberries in Syrup

(F)—Full Diet (S)—Soft Diet FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

2nd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Brisket, Corned	U. S. Good	7 lbs.	20
Chipped Beef, Dried	U. S. Good	5 lbs.	80
Ground Beef	U. S. Good, 5 lb. pkg.	35 lbs.	
Roast, Sirloin (B.RT.)	U. S. Choice	13 lbs.	40
Round (Top, Boneless)	U. S. Good	20 lbs.	60
Steak, Flank		20 lbs.	60
Steaks, Round	U. S. Choice, 4 oz. each	20 lbs.	60
Sweetbreads	Fresh	9l bs.	20
Tenderloin Tip	U. S. Good	27 lbs	80
Tongue	No. 1	13 lbs.	40
LAMB			
Leg (B.R.T.)	U. S. Choice, yearling	7 lbs.	20
Shoulder (B.R.T)	U. S. Good	10 lbs.	40
PORK			
Ham (Pullman)	Ready-to-Eat	25 lbs.	
Loin (Boneless)	Grade A, 10-12 lbs.	25 lbs.	100
Sausage Links	12-1 lb.	10 lbs.	40
VEAL			
Chop, Rib	U. S. Good, 5 oz. each	13 lbs.	40
Cutlets	U. S. Good, 4 oz. each	15 lbs.	60
Leg (B.R.T.)	U. S. Good	7 lbs.	20
FISH			
Perch (Ocean)	Fillets	5 lbs.	20
Salmon	Red, steaks, 5 oz. each	19 lbs.	60

Item, Specifications, Amounts & No. of Servings			
POULTRY			
Breasts, Chicken	6 oz. each	30 lbs.	80
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	60 lbs.	80
Fryers (Eviscerated)	Grade A, 2½ lb. av.	38 lbs.	60
FRESH FRUITS			
Apples	Jonathan, 113s	1 box	
Avocado	Ripe	2 doz.	
Bananas	Ripe	20 lbs.	
Grapes	Seedless, 28 lb. box	½ box	
Lemons		1 doz.	
FRESH VEGETABLES			
Cabbage		15 lbs.	
Carrots	Topped, bag	50 lbs.	
Celery	Pascal, 30s	1 doz.	
Celery	White	1 doz.	
Endive	Curly	1 doz.	
Lettuce	Head, 48s	1 crate	
Onions, Dry	Yellow, bag	50 lbs.	
Onions, Green	Bunch	1½ doz.	
Onions, White	Boilers	3 lbs.	
Parsley	Bunch	1 doz.	
Potatoes, Sweet	Hamper	50 lbs.	
Potatoes, White	Bag No. 1	300 lbs.	
Radishes	Bunch	1½ doz.	
Romaine		1 doz.	

Item, Specifications, Amounts & No. of Servings			
Squash, Acorn		30 lbs.	60
Watercress	Bunch	1 doz.	
FROZEN FRUITS			
Apples	Slices, 8 lb. can, 5-1 sugar	16 lbs.	
Boysenberries	8 lb. can, 5-1 sugar	8 lbs.	
Orange Juice	Con., 32 oz. can	3 cans	
Orange Sections	Fresh, chilled, gallon	1 gal.	
Orange and Grapefruit Sections	Fresh, chilled, gallon	2 gal.	
Pineapple	Fresh, chilled, gallon	1 gal.	
Rhubarb	8 lb. can, 5-1 sugar	8 lbs.	
Strawberries	Sliced, 8 lb. can. 5-1 sugar	16 lbs.	
FROZEN VEGETABLES			
Asparagus	Spears, 2½ lb. pkg.	25 lbs.	150
Beans, Green	Cuts, 2½ lb. pkg.	30 lbs.	180
Beans, Green	Julienne, 2½ lb. pkg.	10 lbs.	60
Beans, Lima	Small, green, 2½ lb. pkg.	2½ lbs	15
Broccoli	Stems and buds 2½ lb. pkg.	5 lbs.	30
Brussels Sprouts	2½ lb. pkg.	2½ lbs.	15
Cauliflower	Buds, 2½ lb. pkg.	5 lbs.	30
Peas	2½ lb. pkg.	25 lbs.	150
Spinach	Chopped, 2½ lb. pkg.	25 lbs.	150
Vegetables, Mixed	2½ lb. pkg.	5 lbs.	30

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3rd WEEK NORTH-NORTHWEST SELECTIVE SPRING CYCLE MENU

(MENUS TO BE USED DURING MARCH, APRIL AND MAY)

—prepared by Olga Wasylyk, director of dietetics, Good Samaritan Hospital, Portland, Ore.

	breakfast	noon	night
monday	Prune Juice (S) or Orange Sections (F) Rice Farina or Ready-to-Eat Malt Flake Cereal Poached Egg with Crisp Bacon	Scotch Broth with Assorted Crackers Hungarian Goulash (F) or Sautéed Liver (S) French Fried Onion Rings or Buttered Spinach with Lemon (FS) Lettuce Wedge with Blue Cheese Dressing or Pineapple-Date Salad with Fruit Dressing Butter Brickle Ice Cream (F) or Chilled Peeled Apricot Halves in Syrup (S)	Blended Fruit Juice Roast Turkey (FS) with Dressing and Giblet Gravy (F) or Crabcakes with Lemon Whipped Potatoes (FS) Buttered Baby Lima Beans or Buttered Carrots (FS) Tossed Salad Greens with Oil and Vinegar Dressing or Fresh Fruit Salad with Honey Cream Dressing Lemon Meringue Pie (F) or Chilled Kadota Figs (S)
tuesday	Grapefruit Juice (F) or Baked Apple (S) Rolled Wheat Cereal or Cornflakes Jelly Omelet Danish Pastry	Cream of Vegetable Soup with Triscuits Veal Pot Pie (FS) or Glazed Ham Loaf with Pineapple Creamed Style Corn or Buttered Asparagus (FS) Pickles and Olives or Frozen Strawberry-Fruit Salad with Mayonnaise Double Decker Brownies (F) or Chilled Pear Half in Syrup (S)	Old Fashioned Navy Bean Soup with Saltines Pot Roast of Beef with Gravy (FS) or Braised Lamb Steak with Gravy Oven-Browned Potatoes (FS) Baked Hubbard Squash (S) or Stewed Tomatoes with Celery (F) Cottage Cheese on Endive with Mayonnaise or Prune and Nut Salad with Honey Cream Dressing (F) Frosted Spice Loaf Cake (F) or Bing Cherries in Syrup (S)
wednesday	Orange Juice (S) or Stewed Fruit Compote (F) Farina or Bran Flake Cereal Soft Cooked Egg and Sausage Patty Toast with Jelly	Gumbo Creole with Wheat Thins Turkey ala King on Biscuit (FS) or Hot Sliced Corned Beef on Rye Bread Buttered Mixed Vegetables or Buttered Green Beans (FS) Potato Salad or Banana-Nut Roll Salad with Fruit Dressing (F) Pineapple Sherbet (F) or Canned Fruit Cup (S)	Cranberry Juice Swiss Steak (FS) or Hot Sliced Tongue with Mustard Sauce Baked Potato with Whipped Butter (FS) Buttered Broccoli or Harvard Beets (FS) Fruited Cole Slaw or Deviled Egg Salad Peach with Custard Sauce (FS) or Gingerbread
thursday	Tomato Juice (FS) or Stewed Rhubarb Whole-wheat Cereal or Ready-to-Eat Rice Cereal French Toast with Syrup and Crisp Bacon	Consomme with Croutons Sweet and Sour Meat Balls with Rice (F) or Large Fruit Plate with Cottage Cheese and Brown Bread (S) Buttered Cauliflower or Buttered Peas (FS) Chef's Salad with Russian Dressing or Fruit Tidbit Salad with Honey Cream Dressing Coconut Layer Cake (F) or Chilled Peeled Apricot Halves in Syrup (S)	Cream of Mushroom Soup with Saltines Breaded Veal Cutlet with Gravy (FS) or Roast Leg of Pork with Country Gravy Scalloped Potatoes (FS) Buttered Brussels Sprouts or Buttered Carrots (FS) Lettuce Wedge with French Dressing or Grapefruit-Apple Salad with Fruit Dressing Strawberry Ice Cream (F) or Chilled Peeled Plums in Syrup (S)
friday	Prune Juice (S) or Grapefruit Half (F) Rice Farina or Shredded Wheat Cereal Poached Egg Cinnamon Toast	Clam Chowder with Oyster Crackers Seafood Casserole (FS) or Hot Sliced Beef on Toast Buttered Baby Lima Beans or Whipped Squash (FS) Raw Relishes or Orange Section Salad with Fruit Dressing (F) Baked Marmalade Custard (F) or Baked Apple (S)	Vegetable Juice Poached Halibut with Shrimp Sauce (FS) or Oven Fried Chicken with Giblet Gravy Parsleyed Buttered Potatoes (FS) Buttered Whole Kernel Corn or Buttered Spinach (FS) Avocado Salad Bowl with French Dressing or Pear and Grated Cheese Salad with Mayonnaise Cherry Pie (F) or Chocolate Ice Cream (S)
saturday	Blended Citrus Juice (F) or Banana (S) Whole-wheat Cereal or Cornflakes Scrambled Eggs Walnut Coffee Cake (F)	French Onion Soup with Saltines Hamburger on Bun (FS) or Roast Beef Hash Buttered Mixed Vegetables or Buttered Asparagus (FS) Sliced Tomato Salad with French Dressing or Peach and Cottage Cheese Salad with Mayonnaise Orange Sherbet (FS) or Fresh Pineapple	Cream of Chicken Soup with Croutons Potted Round Steak (FS) or Roast Leg of Veal (FS) with Celery Dressing and Gravy (F) Hash Browned Potatoes (F) or Buttered Noodles (S) Buttered Stuffed Fresh Mushrooms or Buttered Green Beans (FS) Vitamin Salad Bowl with French Dressing and Stuffed Olives or Fresh Fruit Salad with Chantilly Dressing (F) Chocolate Roll (F) or Royal Anne Cherries in Syrup (S)
sunday	Pineapple Juice (S) or Orange Sections (F) Oatmeal with Brown Sugar or Puffed Rice Cereal Fried Egg and Link Sausage Toast with Jelly	Fruit Cup Roast Sirloin of Beef with Gravy (FS) or Stuffed Pork Chop with Country Gravy Whipped Potatoes (FS) Buttered Shredded Cabbage au Gratin or Buttered Peas (FS) Combination Vegetable Salad with French Dressing or Bunch of Grapes (F) Rhubarb Cobbler (F) or Chilled Peaches in Syrup (S)	Cream of Asparagus Soup with Wheat Thins Veal Sauteed on Noodles (FS) or Brunswick Stew Buttered Broccoli or Buttered Beets (FS) Lettuce Wedge with 1000 Island Dressing or Molded Cherry Salad with Mayonnaise Lemon Custard Ice Cream (F) or Baked Fresh Pear (S)

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread ,butter, and a choice of beverages are to be included with each meal.

PLEASE CUT ALONG THIS LINE

3rd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Brisket, Corned	U. S. Good	13 lbs.	40
Ground Beef	U. S. Good, 5 lb. pkg.	70 lbs.	
Liver	Steer, sliced	5 lbs.	20
Roast, Sirloin (B.R.T.)	U. S. Choice	53 lbs.	
Round (Top, Boneless)	U. S. Good	40 lbs.	120
Steak, Swiss	U. S. Good, 4 oz. each	15 lbs.	60
Stew	U. S. Good	5 lbs.	20
Tongue	No. 1	7 lbs.	20
LAMB			
Steaks, Shoulder	U. S. Good, 5 oz. each	7 lbs.	20
PORK			
Bacon (Sliced)	24-26-1 lb.	6 lbs.	
Chops, Loin	Grade A, 4 oz. each	10 lbs.	40
Ham (Pullman)	Ready-to-eat	10 lbs.	
Loin (Boneless)	Grade A, 10-12 lbs.	7 lbs.	20
Sausage (Bulk)	Lean	10 lbs.	
Sausage Links	12-1 lb.	10 lbs.	40
VEAL			
Cutlets	U. S. Good, 4 oz. each	15 lbs.	60
Leg (B.R.T.)	U. S. Good	7 lbs.	20
Shoulder (Boneless)	U. S. Good	35 lbs.	
FISH			
Halibut	Steaks, 5 oz. each	19 lbs.	60

Item, Specifications, Amounts & No. of Servings			
POULTRY			
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	105 lbs.	140
Fryers (Eviscerated)	Grade A, 2½ lb. av.	13 lbs.	20
FRESH FRUITS			
Apples	Jonathan, 113s	1 box	
Avocado	Ripe	½ doz.	
Bananas	Ripe	35 lbs.	
Grapefruit	Seedless, 70s	½ box	
Grapes	Seedless, 28 lb. box	½ box	
Lemons		1 doz.	
Pears		7 lbs.	20
FRESH VEGETABLES			
Cabbage		15 lbs.	
Carrots	Topper, bag	50 lbs.	
Celery	Pascal ,30s	1 doz.	
Celery		½ doz.	
Endive	Curly	1 doz.	
Lettuce	Head, 48s	1 crate	
Mushrooms	3 lb. basket	6 lbs.	
Onions, Dry	Yellow, bag	50 lbs.	
Onions, Green	Bunch	1½ doz.	
Onions, Spanish-type		3 lbs.	
Parsley	Bunch	1 doz.	
Potatoes, White	Bag No. 1	300 lbs.	
Radishes	Bunch	1½ doz.	
Romaine		½ doz.	
Squash, Hubbard		7 lbs.	

Item, Specifications, Amounts & No. of Servings			
Tomatoes	Repacked (5 x 6)	½ lug (15 lbs.)	
Watercress	Bunch	½ doz.	
FROZEN FRUITS			
Cherries	5-1 sugar, pitted, 8 lb. can	16 lbs.	
Grapefruit Sections	Fresh, chilled, gallon	1 gal.	
Orange Juice	Con., 32 oz. can	3 cans	
Orange Sections	Fresh, chilled, gallon	2 gal.	
Orange and Grapefruit Sections	Fresh, chilled, gallon	2 gal.	
Peaches	Sliced, 8 lb. can, 5-1 sugar	8 lbs.	
Pineapple	Fresh, chilled, gallon	1 gal.	
Rhubarb	8 lb. can, 5-1 sugar	32 lbs.	
FROZEN VEGETABLES			
Asparagus	Spears, 2½ lb. pkg.	30 lbs.	180
Beans, Green	Cuts, 2½ lb. pkg.	25 lbs.	150
Beans, Lima	Small, green, 2½ lb. pkg.	5 lbs.	30
Broccoli	Stems and buds 2½ lb. pkg.	5 lbs.	30
Brussels Sprouts	2½ lb. pkg.	2½ lbs.	15
Cauliflower	Buds, 2½ lb. pkg.	2½ lbs.	15
Peas	2½ lb. pkg.	30 lbs.	180
Spinach	Chopped, 2½ lb. pkg.	25 lbs.	150
Squash, Winter	3 lb. pkg.	24 lbs.	96
Vegetables, Mixed	2½ lb. pkg.	5 lbs.	30

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7 ways to improve patient care and hospital efficiency

. . . through the functional use of communications and sound

Well-planned Executone sound-communication systems can perform heroic labors in the hospital. More than 30 different applications have been designed. Seven broad areas are detailed here. They are capable of lifting many burdens that high costs and personnel shortages impose on patients, administrators and staff.

1. Provide for instant command-response in surgery

Lives can be saved by immediate response to doctors' commands in the Surgical Suite. It is vital that a surgeon obtain assistance from remote departments with as much dispatch as he receives an instrument from his Operating Nurse. He may, for instance, have to suspend an operation until a report on a specimen can be obtained from Pathology . . . until Blood Bank or Sterile Surgical Supply can fill an unforeseen need.

Executone's intercom systems put these services at the surgeon's immediate disposal. They fulfill special requirements of the Operating Room—explosion-proofing . . . foot-operation . . . extremely well-modulated voice reproduction. They can, in addition, be used to transmit 2-way voice communication between the surgeon and students.

In other than surgical areas where urgent situations arise, action can almost always be expedited by properly-specified Executone communications.

2. Raise nurses' productivity; improve bed-patient care . . . in new and existing hospitals

Time and motion studies have proved that nurses' foot travel can be reduced by as much as 65%. At the same time, more duties can be assumed by orderlies, aides and Practical Nurses. The source of these skilled-labor-savings is the Executone audio-visual nurse call system. It can make a reduced nursing staff more responsive to the patients' needs.

In most cases, it can be installed using existing nurse call wiring. An effective audio-visual system will incorporate the following factors:

a. ability of patients, including those unable to move or speak normally, to use the system effortlessly.

b. operation of the system with all its advantages regardless of the location of nurses at any given moment, or the number of calls registered.

c. provisions to avoid a patient's being unable to signal.

d. psychological reassurances—of the proper registration of a patient's call, and the maintenance of his privacy.

e. foolproof, urgent-priority call registration from bathroom stations.

f. use of the system to monitor sounds in post-operative cases, polio or seclusion wards, nurseries, etc.

A demonstration of Executone's advanced nurse call equipment will show you how all these functions and safeguards can be implemented, and a system designed for any set of requirements.

3. Ease doctors' registration and message problems

In-out registration and message collection duties are so burdensome to doctors that many frequently neglect these essentials. Confusion and delays result. Executone, however, makes available a variety of systems designed to relieve this condition. One notable advance is Executone's simplified, one-stop register-and-message facility.

This facility is made available to the doctor at all habitually used entrances. Each register is tied in to a central compact "memory" unit at the hospital message center. The doctor need only punch

his own 3-number code into the nearest register and indicate whether he is entering or leaving. This information is stored in the "memory" unit and is instantly available at *any* register. If there are messages for a doctor when he uses a register, a blinking light alerts him, and he may speak to the message center by 2-way intercom. The use of a central "memory" unit makes possible significant economies in wiring.

4. Increase the versatility of doctor-paging systems

The paging facilities in today's hospital can offer a far greater range of service—thanks to Executone's multi-purpose systems. Not only does this equipment make possible a variety of interchangeable paging methods, but it will accommodate background music and alarm functions as well.

In addition to the conventional all-hospital page, the Executone-equipped paging center may use:

zoned paging. A sequence of zoned pages will usually locate a doctor without disturbing the entire hospital. A typical sequence might be: obstetrical suite . . . maternity ward . . . doctors' lounges and dining rooms.

localized paging. This system operates as above—with this exception: On floors or wards served by nurses' stations, paging is restricted to the duty area. The nurse completes the page by selective use of the nurse call system. This method gives maximum quiet in patient areas.

5. Make the hospital environment more congenial

Sound can be genuinely therapeutic. Leading administrators attach great importance to its use for diversion and entertainment. They favor the availability of music—in wards and labor rooms, for example, as well as waiting rooms and visitors' facilities. Chapel services can be transmitted to the rooms of patients who so desire.

Executone's versatile paging and nurse call systems readily handle these additional functions. For example, each patient can be supplied with an Executone Pillow Speaker and controls. This remarkably compact instrument is a high quality sound reproducer . . . radio station and TV channel selector . . . volume control . . . and nurse call cord set—all in one. No radios are needed in the rooms. Programs—and records or tapes—originate at a central control rack.

6. Speed internal action; keep telephone lines free

Reliance on the telephone for internal communication in the hospital often results in delay and switchboard congestion. Efficiency requires a channel of communication independent of the telephone . . . in order that administrators may have direct contact with heads of departments . . . that related departments be in instant touch with one another . . . that there be adequate intercom facilities within departments.

Executone's intercom systems have proved their worth in hundreds of hospitals — in terms of increased staff productivity, time savings, and freeing switchboards for rapid response to emergency calls.

7. Expedite out-patient, clinic and emergency service

Traffic can be made to flow smoothly, and doctors' time conserved, by effective communications in departments serving ambulatory patients. Emergency admissions, too, can be handled with efficiency . . . day and night.

Executone intercommunication — between nurses' stations and the medical facilities they serve — is the key to improved operation in these areas. An ambulance entrance which is not regularly staffed at night can be made functional around the clock—by the use of an outdoor Executone ambulance intercom station to summon proper personnel upon arrival of an emergency case.

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IN-USE STUDIES OF THE EFFECTIVENESS OF AN ANTIBACTERIAL SOAP ON HOSPITAL LINENS

by J. H. SILLIKER, Ph.D., C. E. JANSEN, J. M. BECKTEL and L. R. SCHILTZ

The authors report a study of the *Staphylococcus aureus* count in urine-soaked diapers from five hospitals—three of them using a germicidal laundry soap and two acting as controls. They also describe the test procedure and give a detailed report of the results of the experiments.

THE EMERGENCE of nosocomial *Staphylococcus aureus* infections as a significant public health problem has focused attention on all areas in the hospital environment, which could conceivably play a role in *Staphylococcus aureus* transmission. One potential link in the spread of *Staphylococcus aureus* infection is the laundry. This was recognized in the recommendations of the National Conference on Hospital-Acquired Staphylococcus Disease held in Atlanta in 1958:

"It is recommended that great care be given to insure that contaminated linen and blankets, particularly from patients with staphylococcal disease, not be mixed with other laundry, that contaminated trucks not be used for transporting clean laundry and that clean and dirty laundry never be transported concurrently. Evidence suggested that sheets, blankets and mattresses may play a role in the spread of infection, and thus deserve special attention."

J. H. Silliker, Ph.D., C. E. Jansen, J. M. Becktel and L. R. Schiltz are all associated with the Research Laboratories of Swift and Co., Chicago.

Considerable effort has been expended to determine the potential sources of contamination of finished linens within the laundry. Ridenour[1] made an extensive study on factors affecting the efficiency of the laundering operation in the removal of bacteria from soiled fabric. Church and Loosli[2] investigated the source of organisms found in laundered materials. Their studies pointed out the dangers of cross contamination of laundered fabric from sorting tables as well as the danger of contaminating washed fabric during the spin drying process. Blowers[3] and Ravenholt[4] et al concerned themselves with methods of destroying bacteria in blankets and similar materials which cannot be given high temperature laundering.

Although the laundry environment constitutes a potential source of contamination of fabric, careful handling and control over its operations should produce linens which are free of staphylococci. From the time the fresh linens leave the laundry until they return, they are subject to bacterial contamination. When they become contaminated with organic material, a focus of infection may be initiated.

INFECTION-CONTROL EFFORTS

A number of commercial products have been developed for the purpose of impregnating fabric with antibacterial materials in order to prevent the relatively bacteria-free linens from becoming a source of infection after leaving the laundry. For the most part, the antibacterial agents are added as a solution or a suspension to the rinse water during the last rinse. As Chapin[5] has indicated, a wide variety of antibacterial chemical agents have been utilized, and the choice of the agent is dependent upon the particular use intended.

In our experience, these laundry additives, when used according to

manufacturers' directions, do impart antibacterial activity to the fabric. When such linen is subjected to appropriate laboratory test procedures, such as the agar plate method of Schwartz et al[6], it is easily demonstrated that fabric containing effective germicides is capable of inhibiting the growth of staphylococci.

Although it is quite simple to demonstrate the activity of an antibacterial agent in properly treated fabric, the question arises as to whether this activity is of practical importance in the control of a specific organism in the hospital environment.

MOISTURE FOR "MOBILIZATION"

Stuart[7] has pointed out that the activity of a residual antibacterial agent requires contact between the microorganism and the toxic chemical. This contact has been referred to by the term "mobilization". Stuart asserted that with a dry, living bacterical cell carried by a completely dry surface in the absence of atmospheric humidity, no mobilization of any residual chemical other than a gas could be expected. Thus in the dry state, the incorporation of a chemical active against staphylococci would not be of any practical significance.

This leaves unanswered, however, the question of utility with regard to objects which may be exposed to moisture; viz., wash cloths, towels, diapers and bed linens. Does the presence of an antibacterial material in such fabrics afford any protection to the patient or the hospital environment? Few studies have been conducted which allow definitive answers. Propst[8] showed a reduction in bacterial contamination on wet surgical linen treated with a quaternary ammonium germicide in the last rinse as compared to untreated linen.

Hudson et al[9] indicated that substantial reductions in the bacterial population of the hospital environment can be obtained in a maintenance program designed to include a routine providing for the periodic application of contact disinfectants with residual activities in what has been described as a "total saturation technique". In this study the linens as well as a wide variety of other materials were treated to provide for the presence of a residual germicide. The over-all program did reduce the bacterial population, but the linens were not specifically segregated in this study.

Phillips[10] conducted in-use tests on sheeting which was impregnated with a residual bacteriostatic agent. He could demonstrate no difference in the number of viable bacteria carried by untreated sheets and sheets treated with a residual agent, after actual use.

The present study was undertaken in an effort to evaluate the efficacy of treating diapers with a soap containing bactericides which are substantive to fabric. This study involved comparing the *Staphylococcus aureus* content of soiled diapers from three hospitals using the germicidal soap with the *Staphylococcus aureaus* content of diapers obtained from two hospitals utilizing similar laundry techniques, but with neither germicidal soap nor rinse additives being used.

METHODS OF THE STUDY

The five hospitals involved in this study were of moderate size (200 to 300 beds). All laundering was done by the hospital laundry department.

Diapers were obtained from the pediatrics wards of each of the hospitals. The samples were collected by the nursing personnel during the night and picked up the following morning. The attending nurse removed the diaper from the patient and placed it immediately in a sterile plastic bag. The diapers were all soiled with urine, but not with visible fecal matter. Because of the method of collection, individual samples were held from one to 12 hours at room temperature before their arrival at the laboratory for analysis.

Control hospital A was studied over a period of 16 successive days (excluding week ends), with three diapers per day being examined. Treated hospital B was originally surveyed with the examination of 17 diapers on a single day. The following week, four to six diapers per day were picked up from treated hospitals A, B and C, and control hospital B.

BACTERIOLOGICAL PROCEDURES

Analysis of samples involved adding 500 ml. of sterile dilution water directly to the bag containing the test diaper. The dilution water was squeezed in and out of the diaper vigorously by hand to obtain the best possible sample. Determination of staphylococci was accomplished by surface plating on tellurite glycine agar (Zebovitz[11] et al). Since no more than 0.1 ml. of sample can be plated

TABLE 1

The *Staphylococcus aureus* Content of Urine Soaked Diapers

Hospital	Samples Tested	Staphylococci Per Diaper: Log. Average of Counts	Staphylococci Per Diaper: Antilog of Log. Average
Treated*			
A	42	4.456	28,600
B	23	4.129	13,500
C	24	4.580	38,000
Average	89	4.402	25,100
Control*			
A	48	6.872	7,450,000
B	30	6.521	3,320,000
Average	78	6.696	4,970,000

*Hospitals using germicidal laundry soap.
**Hospitals using no germicides in laundry formulas.

TABLE 2

The Effect of Germicidal Soap on the *Staphylococcus aureus* Content of Soiled Diapers: Summary of the Analysis of Variance

Source of Variation	Degrees of Freedom	Mean Square
Treatments (With vs. Without Germicidal Soap)	1	266.66**
Hospitals Within Treatment	3	2.41
Days Within Hospitals	31	3.66
Diapers Within Days	131	2.06

**Highly significant (P. <.01)

TABLE 3

The Occurrence of *Staphylococcus aureus*—Negative Diapers (<5000) in Treated vs. Control Hospitals

	Positive	Negative	Total
Treated Hospitals	29	60	89
Control Hospitals	70*	8	78
Total	99	68	167

*Chi square test indicated probability <0.05 per cent.

directly on tellurite glycine agar, the first dilution of the sample was one to 5000; therefore, the limit of the analysis was 5000 staphylococci per diaper.

The plates were incubated 24 hours at 37°C., after which colony counts were made. On positive samples, five colonies from the counted dilution were selected at random and subcultured in brain-heart infusion broth. Where less than five colonies were found, all were subcultured. The broth cultures were incubated 24 hours at 37°C. Coagulase tests were then carried out according to the method of Chapman et al[12].

Unused diapers were obtained from each of the hospitals and analyzed for staphylococci according to the methods outlined above. These diapers were found to be free of staphylococci within the limits of the procedure (less than 5000 per diaper).

Unused diapers from both treated and control hospitals were tested for residual germicidal activity against a mixture of coagulase positive staphylococci using a modification of the agar plate method (Schwartz et al[6]). Diapers from the treated hospitals uniformly showed the ability to prevent *Staphylococcus aureus* growth in the zone of contact between the fabric and the inoculated agar. Fabric from control hospitals showed no activity against the test organisms utilizing this procedure.

The *Staphylococcus aureus* counts were transformed to logarithms for the purpose of statistical analysis.

RESULTS OF THE STUDY

In Table 1 (see page 97) are summarized the average *Staphylococcus aureus* counts of diapers collected from each of the five hospitals. It will be noted that the three hospitals using germicidal laundry soap showed an average *Staphylococcus aureus* count per diaper of 25,100 whereas the two control hospitals showed an average of approximately 5,000,000. These values constitute a 99.5 per cent reduction in staphylococci as a result of using the germicidal soap.

In the adjacent figure, the averages of the logarithms of the *Staphylococcus aureus* counts in each hospital are represented with horizontal bars, and the 95 per cent confidence intervals* for these averages are shown by the vertical arrows. The analysis of variance (see Table 2, on this page) indicates that the differences observed between treated and control hospitals are highly significant; i.e., there is less than one chance in 100 that the differences observed could be due to chance variations alone. Furthermore, the variation between hospitals within each of the two treatment groups was not significant, nor was there a significant variation from day to day in the results from a given hospital.

*The 95 per cent confidence interval is that range of *Staphylococcus aureus* counts within which, with 95 per cent probability, the true average count for that hospital may be expected to lie.

In the tabulation of results, the limit of the analytical procedure used in determining the numbers of staphylococci per diaper was less than 5000. For the purposes of arriving at average counts for hospitals, it was necessary to assume a count of 5000 per diaper on all samples from which no staphylococci were detected. It is apparent, therefore, that all counts shown here are slightly higher than the true value.

EFFECTIVENESS OF TREATMENT

In Table 3 (on this page) are tabulated the results for positive samples (those in which any staphylococci were detected) and all negative samples (those samples in which no staphylococci were detected). Some staphylococci were detected in approximately 33 per cent of the diapers from treated

THE EFFECT OF GERMICIDAL SOAP ON THE STAPHYLOCOCCUS CONTENT OF SOILED DIAPERS

MEANS AND 95% CONFIDENCE INTERVALS

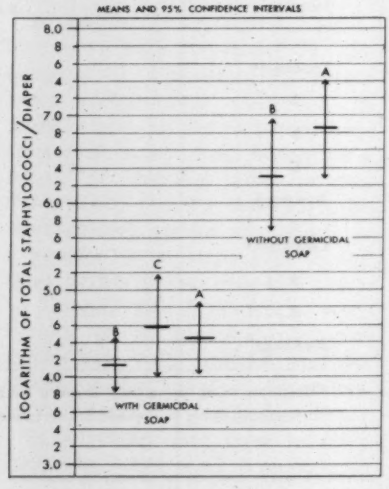

TABLE 4

The Occurrence of Coagulase Positive *Staphylococci* in Diapers—Treated vs. Untreated Hospitals

Hospital	Number of Colonies Tested		
	Positive	Negative	Total
Treated			
A	45	25	70
B	33	37	70
C	29	16	45
Total	107	78	185
***Control* (Untreated)**			
A	236	87	323
B	93	41	134
Total	329*	128	457

*Chi square test indicated probabiltiy <0.05 per cent.

hospitals; in contrast, 90 per cent of the diapers from control hospitals contained staphylococci in numbers detectable by the analytical procedure. Statistical analysis of these data indicated that the differences between treated and control hospitals are highly significant—the chances being less than 5 in 10,000 that the observed differences could be due to chance alone. Thus treatment with germicidal soap significantly reduced the number of diapers containing any detectable staphylococci.

The results obtained in coagulase tests conducted on randomly selected colonies in positive samples are summarized in Table 4 (on this page). It will be noted that approximately 58 per cent of the tested isolates from the treated hospitals were coagulase positive and that 78 per cent of the isolates from the control hospitals were positive. The difference between control and treated hospitals in this respect is significant at the 0.05 per cent probability level.

The five hospitals included in this study were well maintained, orderly and aware of the threat of hospital-acquired *Staphylococcus aureus* infection. None of the hospitals was experiencing a high incidence of *Staphylococcus aureus* infections. Yet, soiled diapers obtained from the control hospitals contained staphylococci in numbers sufficiently high to indicate that growth was occurring in the contaminated fabric. Further, 78 per cent of the staphylococci were coagulase positive.

These findings indicate that in the control hospitals, the soiled diapers constituted a focal point for the initiation of *Staphylococcus aureus* infection in the patient and for cross infection in the hospital environment. In contrast, results in the treated hospitals suggest inhibition of *Staphylococcus aureus* growth. The data in Table 2 (see page 98) show clearly that the two *Staphylococcus aureus* populations (control and treated) are quite different, because there was no significant variation between hospitals using a given treatment nor between findings for different days in a given hospital.

The results demonstrate quite conclusively that an antibacterial residue in diapers is of practical value with respect to the control of staphylococci in the hospital environment. We would emphasize that diapers uniquely qualify for effective use of a residual antibacterial agent. The presence of moisture allows the mobilization of the residual germicides. The failure of Phillips[10] to observe a difference between treated and untreated sheets probably can be attributed to the absence of sufficient moisture to mobilize the residual chemical employed. It is obvious, however, that in the absence of moisture, such inanimate objects as sheets, towels, wash cloths and face masks are not foci of bacterial growth. Such linens are subject to moistening, however, either intentionally or accidentally during the course of their use. Under these conditions, there is no reason to believe that a residual chemical would be any less effective than was observed on diapers.

SUMMARY

The *Staphylococcus aureus* content of urine-soaked diapers from the pediatrics wards of five hospitals was studied. Three of the hospitals (treated) were using a germicidal laundry soap; two hospitals (control) were using no germicides in their laundering operation. The treated hospitals showed an average *Staphylococcus aureus* count per diaper of 25,100, whereas the control hospitals showed an average of approximately 5,000,000. This 99.5 per cent reduction in *Staphylococcus aureus* count demonstrates quite conclusively the practical value of antibacterial residues in linens for hospital use. ■

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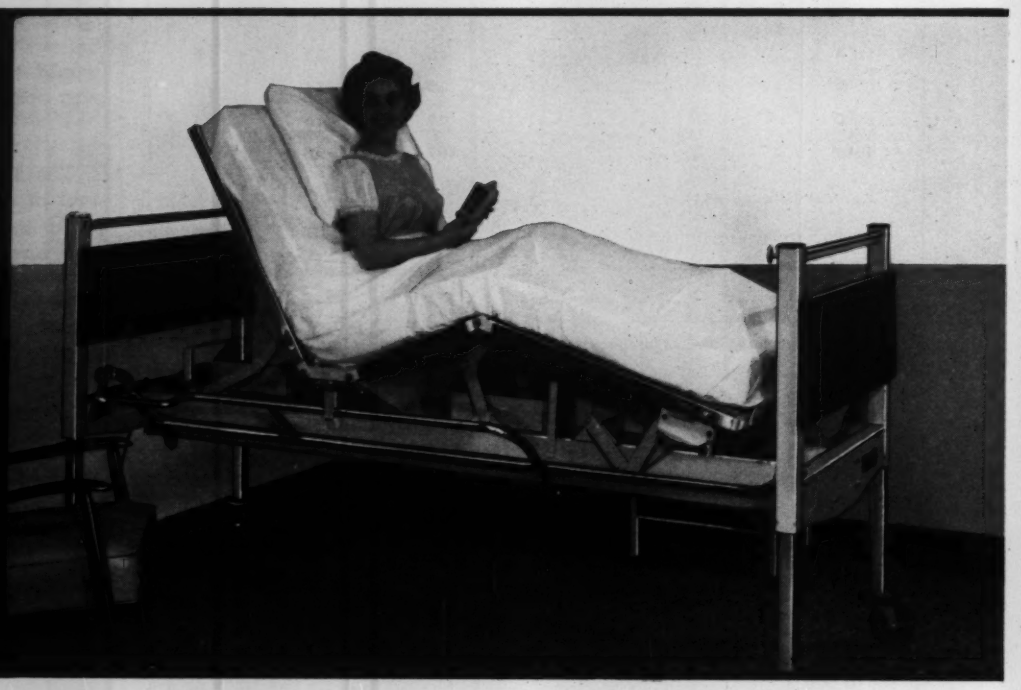

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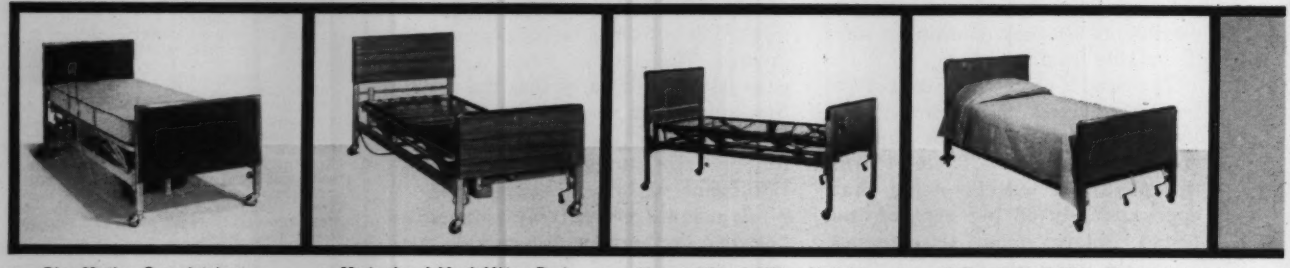

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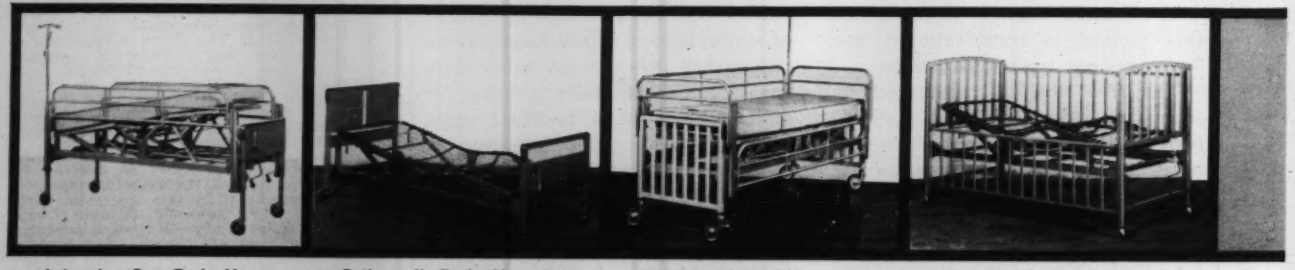

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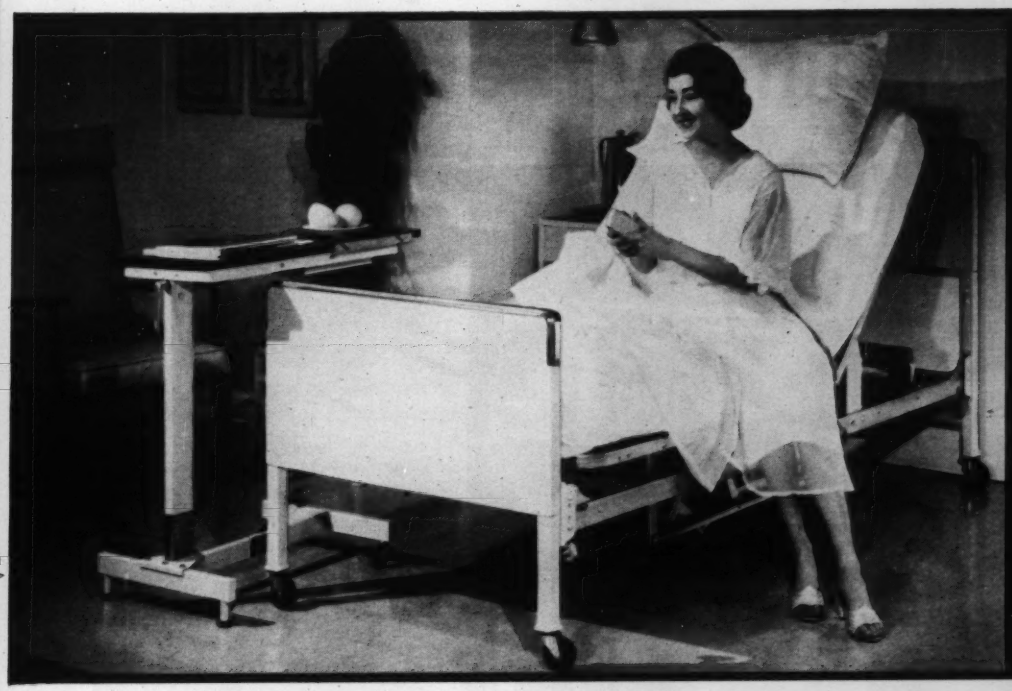

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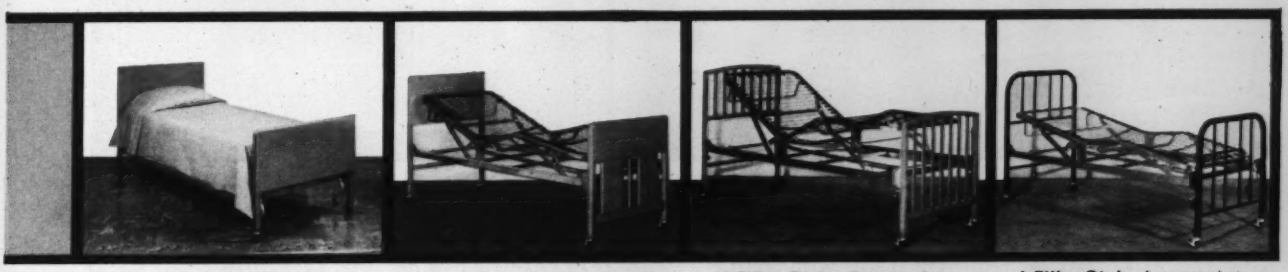

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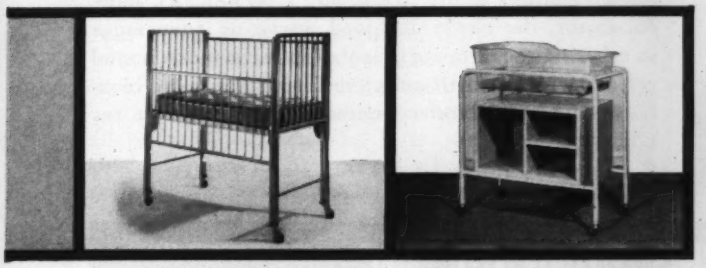

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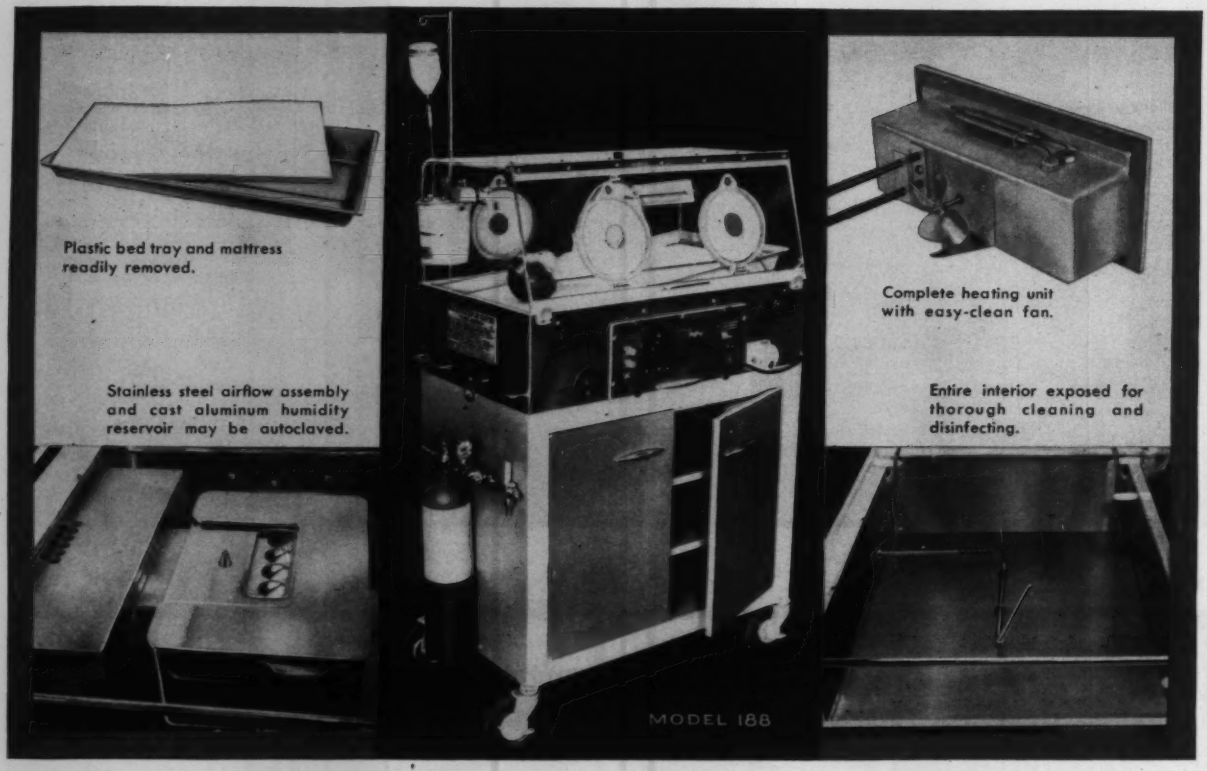
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FOOD SERVICE IN INDUSTRY AND INSTITUTIONS. John W. Stokes, Dubuque, Ia., William C. Brown Co., 1960. 261 pp. $8.

Mr. Stokes has presented and interpreted a compilation of operational facts, figures, procedures and points of view for industrial and institutional food service management. Illustrations throw into focus and balance the factual material page by page. The resulting format is effective and easy to read.

The first part of this book summarizes information on organizational patterns and procedures; equipment and layout standards; purchasing, receiving and storage facts; menu planning and food preparation considerations. The distribution and service of food are discussed in terms of hospital food service. The author describes and evaluates centralized and decentralized food distribution to patients as well as modifications of these two types of service; e.g., mobile cafeteria, air line service, mechanical conveyor, thermally-sealed insulated containers and dry heat systems.

The last section spells out the elements of food cost control, the utilization of food service labor, the detail of certain other expenses and overhead charges, and presents a simple explanation of operational statements, reports and budgets. Hospital observations and the hospital point of view thread a certain continuity through the chapter sequence. Mr. Stokes has, however, also included industrial and college cafeteria ideas, applicable to hospitals, from his experience as a food service consultant.

This is an interesting, ambitious book that provides a composite of current operational practices in an all-inclusive framework; it is a good reference for the person who knows food service management, a valuable tool for the less sophisticated operator.—KATHERINE M. HART, *head of the Department of Institutional Administration, Michigan State University.*

Nursing administration as a career

THE CHIEF NURSE IN THE SMALL HOSPITAL. Fauntella T. Jensen. New York, Springer Publishing Co., 1960. 128 pp. $2.50.

Administrators of small hospitals should welcome this book as a possible aid to interesting registered nurses in nursing administration.

In the preface of the book the author states, "We are not concerned with the highly-prepared nurse who is proficient in nursing administration . . . We wish to

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explore the possibility offered to any registered nurse to become a leader in an area where leaders are in short supply, namely, the smaller hospital which has sprung up in such prodigious numbers across the nation in the last few years."

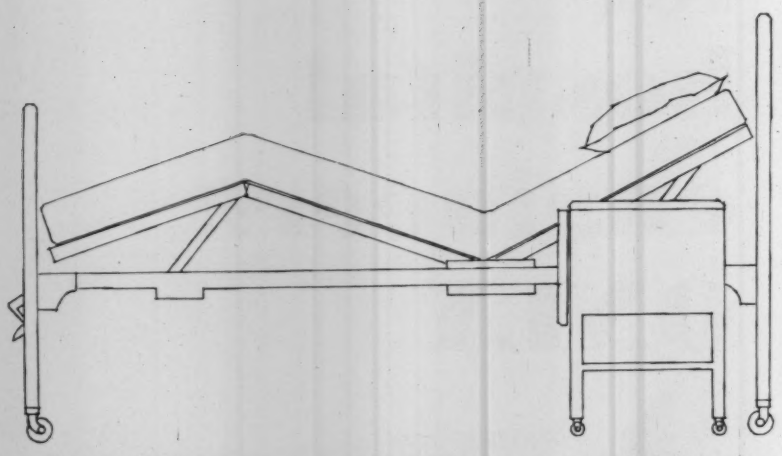
She also says, "It is hoped that this book will not only provide a guide for the nurse already engaged in directing the nursing department in a small hospital but will also stimulate an interest in leadership among those professional nurses who might have exempted themselves out of the mistaken notion that only those with a degree need apply."

This 128-page book is very readable. The author discusses all the departments of the hospital in which the director of nursing service would have responsibility. Included also are discussions on policies, budget, staff meetings, nurse-physician relationship, disaster planning, relations with the press, legal liabilities and case histories.

Throughout the book, the author encourages the reader to refer to other sources for further information and help in directing the nursing service.

I think this book can be a challenge to any registered nurse who is interested in leadership.—DINA BREMNESS, R.N., *superintendent, Glenwood Community Hospital, Glenwood, Minn.*

FUND-RAISING SUCCESS



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During the past two years, with Ketchum, Inc. fund-raising counsel, 25 communities throughout the nation have added enough hospital facilities to care for a city with the population of 689,000 people. Ketchum, Inc.-directed hospital campaigns have totalled $26,933,749. In addition to 1932 new beds, funds raised provided nurses' homes, maternity and nursery facilities, emergency and out-patient equipment, operating, X-ray and recovery rooms.

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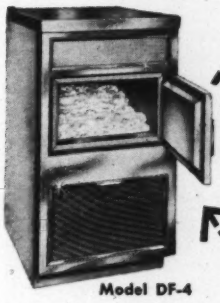
Introductory building maintenance

PROFESSIONAL CLEANING AND BUILDING MAINTENANCE. Bill Clark. New York, Exposition Press, 1960. 344 pp. $6.

This book is written specifically for those who want to establish a business of cleaning and building maintenance.

Using a conversational style, the author covers all aspects of building maintenance, which the newcomer to the field should know, but to the average hospital housekeeper it will not contribute to what she already knows because little of the material is original. The material is applicable to hospital maintenance and housekeeping so far as the charts and procedures are concerned, although they are scattered throughout the book. The lack of an index makes it difficult to refer to specific charts for information.

The material is presented in three parts covering "the field of sanitary maintenance and labor", "floor maintenance technique" and "building care services". Basically, the author describes in detail the levels of cleaning, the need for training and good supervision, the development of "specialists", the do's and dont's of establishing a new business and the differences between routine care and project work. The subjects are explained in too much detail with too many diversions; these force the reader to continually review for clarification. Thus, only the newcomer in the field would consider the book of some value.—LELAND J. MAMER, *manager of plant and maintenance, New York University, Bellevue Medical Center.*

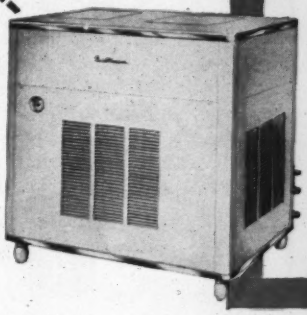


Model DF-4

from 100 LBS. per day...

to 4,500 LBS. per day!

Model SF-8



SCOTSMAN *Super Flakers* supply small, MEDIUM or LARGE Flaked Ice Requirements!

A FULL RANGE of capacities . . . that's what you see when you inspect the SCOTSMAN Line of *Super Flaker* Ice Machines . . . world's largest line, world's largest seller!

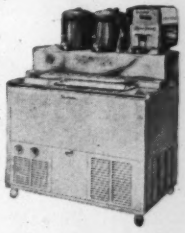
Shown above are the smallest and the largest . . . and there are many models in between!

MODEL DF-4 (left) makes up to 4 lbs. per hour (or up to 100 lbs. per day) of famous SCOTSMAN *Super Flakes* . . . stores up to 35 lbs. in its own stainless steel bin.

MODEL SF-8 (right) is SCOTSMAN's giant capacity *Super Flaker* that makes up to 4,500 lbs. per day . . . gives you a continuous flow of perfect SCOTSMAN ice flakes into the storage bin installation of your choice.

Model SD-1 mounts two soft drink dispenser heads . . . makes up to 350 lbs. of Super Flakes daily.

Model SD-2 has three dispenser heads. Can supply up to 500 lbs. of Super Flakes daily.



OTHER SCOTSMAN SUPER FLAKERS . . . both of the self-storing and continuous-flow variety . . . fill out the capacity range between these two extremes . . . meet any in-between need for 100% pure flaked ice.

IN ADDITION, SCOTSMAN now has *two* models of its Combination Ice Machine and Drink Dispenser . . . with ice making capacities of either 350 or 550 lbs. of ice flakes per day, and mounting either two or three standard one gallon dispenser heads.

Both of these amazing models, which give you *both* ice and iced drinks from the *same* machine, are illustrated at left.

SO REMEMBER . . . if you use flaked ice *at all* in your business . . . even as little as a few pounds per hour or as much as 2¼ tons per day . . . only SCOTSMAN has all the models to fit all your needs exactly! See them today at your nearby home area Ice Machine Specialist . . . your SCOTSMAN Dealer or Distributor.

(*And remember, also, that Scotsman makes a complete line of Super Cubers and Super Bins . . . ask to see them, too!*)

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breath means monaghan

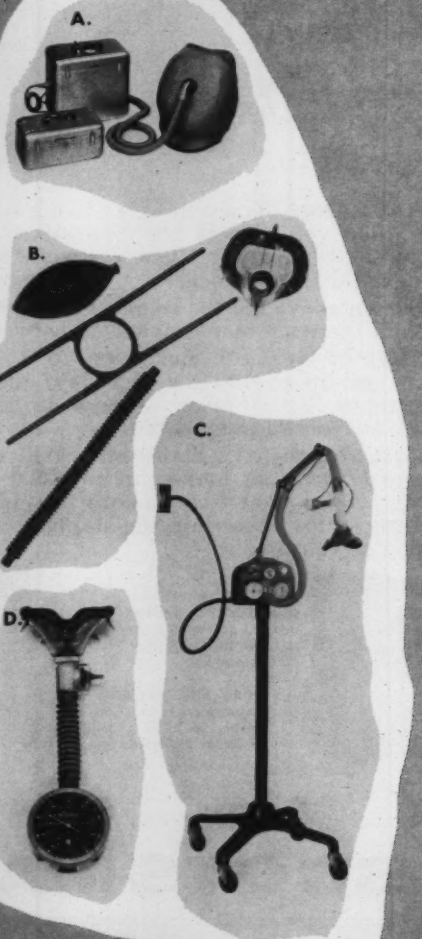
The products listed below can mean life itself through therapeutic breathing for your patients. Peerless reliability, a product of years of experience, assures your patients of the ultimate in respiration.

C. VENTALUNG Dependable intermittent positive pressure breathing—simple to operate. Little patient effort needed. Intermittent or continuous nebulization. Operates from piped or cylinder source to mix oxygen from 40% to 100% in air. Pushbutton or automatic resuscitation. Available also in pediatric model.

A. PORTABLE RESPIRATOR Useful with shell and seal for complete, continuous ventilation, with face mask, mouthpiece or tracheotomy adapter for deep-breathing therapy or emergency. Operates on 115v AC or 12v DC or from rechargeable battery pack. Rugged, completely portable.

D. VENTILATION METER Accurately and continuously measures vital capacity, tidal volume and minute volume of air or any gas received by the patient. Useful in clinical examinations, anesthesia, research, and to determine mechanical respirator volumes.

B. CONDUCTIVE AND NON-CONDUCTIVE NEOPRENE PRODUCTS Masks, bags, tubing of all sizes, head harnesses, all types of oxygen therapy equipment, tracheotomy tubes, adapters and connectors of unusually high quality.



Pictured are only a few Monaghan breathing products; for further details . . .

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personnel changes

● **Allen W. Byrnes, M.D.,** director of professional services at the Veterans Administration hospital at St. Cloud, Minn., has been named manager of the VA hospital at Knoxville, Iowa. He succeeds **Albert L. Olsen, M.D.,** who has been transferred to the VA hospital at Sheridan, Wyo.

● **Duane T. Houtz** has been appointed assistant director of the University of Florida's Teaching Hospital and Clinics. A graduate of Kansas University with a master's degree in hospital administration from Washington University, Mr. Houtz was previously a resident in hospital administration at Orange Memorial Hospital, Orlando, Fla.

● **Theodore L. Jacobsen** has been appointed as executive director of Lutheran General and Deaconess Hospitals, Park Ridge, Ill. He received his master's degree in hospital administration from the University of Minnesota, and was formerly administrator of the Morton F. Plant Hospital, Clearwater, Fla. Mr. Jacobsen was president of the Florida Hospital Association in 1958-1959.

● **Robert H. Larson** has been appointed assistant administrator of Morristown (N.J.) Memorial Hospital. The position was formerly held by **Robert C. Cox.** Mr. Larson is a graduate of the course in hospital administration at the State University of Iowa, and has served as administrative resident and assistant to the administrator at Morristown Memorial Hospital.

● **Thomas J. McKula** has been appointed administrative assistant at Columbia Hospital, Milwaukee. He was previously the administrative assistant at Cincinnati General Hospital. Mr. McKula has a degree in hospital administration from the University of Pittsburgh.

● **Wiley W. Mosley** has been appointed assistant administrator of Ouachita County Hospital, Camden, Ark. He was formerly office manager of the hospital.

● **Albert L. Olsen, M.D.** (see Byrnes item).

● **John B. Perkins** has been appointed administrator of the Rehabilitation Institute of Chicago. Mr. Perkins was formerly associated with the Christian Herald Association, Inc., New York City, where he was treasurer-business manager of the philanthropic organization. He was previously in clinic management and hospital administration in Chicago.

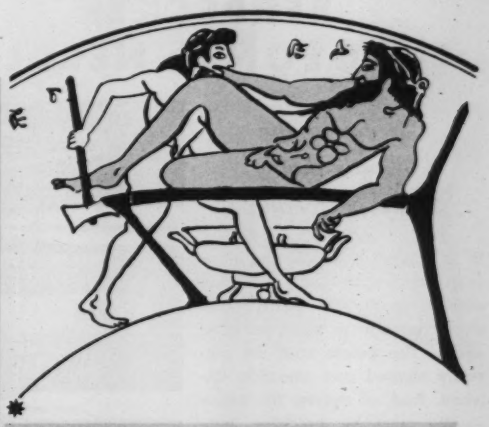
● **David A. Peters** has been appointed director of Episcopal Hospital, Philadelphia. He succeeds **Lucius R. Wilson, M.D.,** who has been appointed to head Episcopal's new development program. Dr. Peters has served at Episcopal Hospital since 1956, first as an administra-

PROCRUSTEAN...*

In ancient Greece, the jolly bandit chief, Procrustes of Attica, maintained an iron bed for the convenience of those whom he captured. On one point only, he was firm . . . they *must* fit his bed. If they were too short, he stretched them out. If too long, he shortened them with an ax. Hence the term "procrustean."

Similarly, there are fund-raisers who would force the same format on all their clients. Very naturally, this *can* prove not only uncomfortable, but sometimes damaging.

Haney Associates, with more than a third of a century of experience, has the know-how to find the one of many types of campaigns which will best fit *your* situation, from the standard, intensive campaign to the long-term development program. Another reason why, in fund-raising, HANEY means QUALITY.



Procrustes gets his "come-uppance" as Greek hero Theseus turns the tables, shortening Procrustes' legs on his own bed. From an ancient Greek drinking cup in the Greco-Etruscan Museum, in Florence, Italy.

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MEMBER AAFRC

A HALLMARK OF ETHICAL FUND-RAISING

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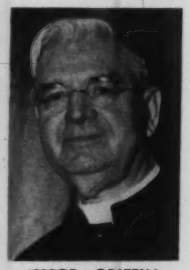
tive resident and later as assistant director. He is a member of the American College of Hospital Administrators and the American Hospital Association.

● **John A. Russell** has joined the staff of the University of Wisconsin Hospitals, Madison, as third assistant superintendent and instructor of hospital administration. He received the degree of master of hospital administration from the University of Michigan in 1958, and has been associated with Evanston (Ill.) Hospital as assistant administrator since 1959.

● **Lucius R. Wilson, M.D.,** (see Peters item).

Deaths

The Rt. Rev. Msgr. Maurice F. Griffin, 80, former trustee of the American Hospital Association and founder and organizer of the Catholic Hospital Association, died in Miami, Fla., January 25.



MSGR. GRIFFIN

Msgr. Griffin, a priest of the Catholic Diocese of Cleveland for more than 52 years, began his career in hospital work soon after his first assignment as a priest in Youngstown, Ohio. He served on the Municipal Hospital Council, and was in charge of three Red Cross hospitals there during World War I.

The monsignor was one of the founders and organizers of the Catholic Hospital Association, and served as vice president from 1929 to 1941. He was also a founder and president of the Ohio Hospital Association, as well as serving for 30 years as its treasurer and representative on the Industrial Commission of Ohio.

Msgr. Griffin was a trustee of the American Hospital Association from 1920-1928, and again from 1931-1945. He was active on numerous committees with the Association and was a leader in the development of Hospital Service Plans under the sponsorship of the AHA, and in the establishment of **HOSPITALS,** J.A.H.A. He was an honorary fellow of the American College of Hospital Administrators.

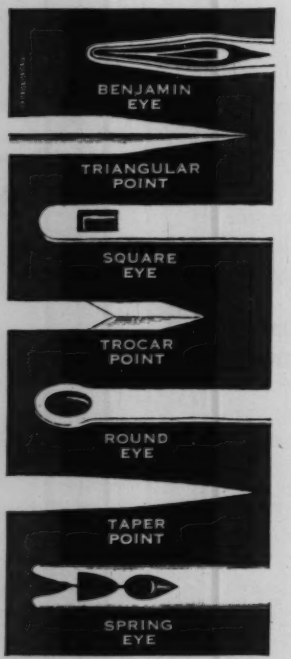
In addition to many honors conferred upon him by the church, Msgr. Griffin was made honorary LL.D by his alma mater, Notre Dame, and was recipient of the AHA Award of Merit. He was honored as a Blue Cross pioneer in 1955.

Alexander M. MacNicol, 64, hospital accounting specialist, died January 16 at Mount Sinai Hospital in Miami Beach, Fla. Mr. MacNicol, an authority on hospital accounting systems, was the senior partner of MacNicol, Johnson and Co., South Orange, N.J. He joined the firm in 1920 and became a partner eight years later.

Mr. MacNicol was a member of the New York Society of Certified Public Accountants, the Institute of Accountants, the American Hospital Association and the New Jersey Hospital Association. He was a frequent speaker on the accounting problems of hospitals.

BERBECKER SURGEONS' NEEDLES

Correct in the details that make perfection



In a surgeon's needle the eyes must be streamlined, yet open enough to thread easily, and sturdy enough to stand suturing strain. The points must be correctly shaped and smoothly finished. And, of course, the entire needle must be precision tempered against bending or breaking.

Berbecker Needles have these qualities because they are made in England by specialists whose needle making skill has descended from generations. Because of this, Berbecker Needles are used in hospitals in every state. In many hospitals they are the only needles used. Available at surgical dealers.

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AN ALL-CHROME PATIENT LIFT

Not a special model . . . but the *new standard* PORTO LIFT, at NO INCREASE IN COST. New, life-long finish and dependable hydraulic action make PORTO LIFT a "must" for effortless patient handling.

PORTO-LIFT
MANUFACTURING CO.
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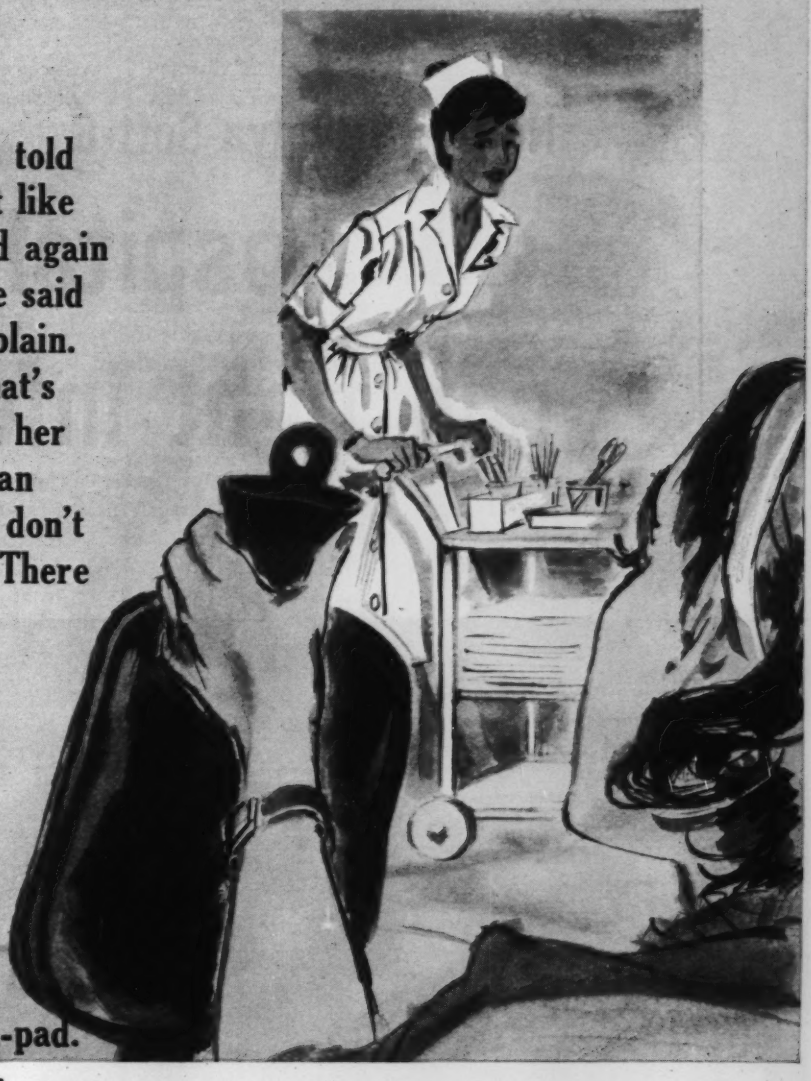
"Hey Nurse.... my hot water bottle's cold"



O. K.... now I've been told ..."Oh Nurse... I don't like to complain but it's cold again and I've got a pain" She said she doesn't like to complain. Well Brother, it's me that's getting the pain. It's not her fault, really, but what can I do? Why in the world don't we get something new? There must be a simpler and easier way than filling bottles the whole live long day. Why can't we get one that's automatic, where the temperature is not so erratic, there is, you say? Well, I'm sure glad. Praise the Lord and pass the K-pad.

aquamatic K *pad*

Eliminates the tedious ritual of filling, checking and replacing. Flexible pad drapes and moulds lightly to contours to provide maximum contact. Several sizes available including 14" x 3" model for rectal compresses and post partum use. The "set and forget" Control Unit maintains desired temperature, constant to within 1°F. Contains a three week supply of distilled water and is whisper quiet. For complete information write Gorman-Rupp Industries, Inc. or ask your American Hospital Supply Corp. representative.

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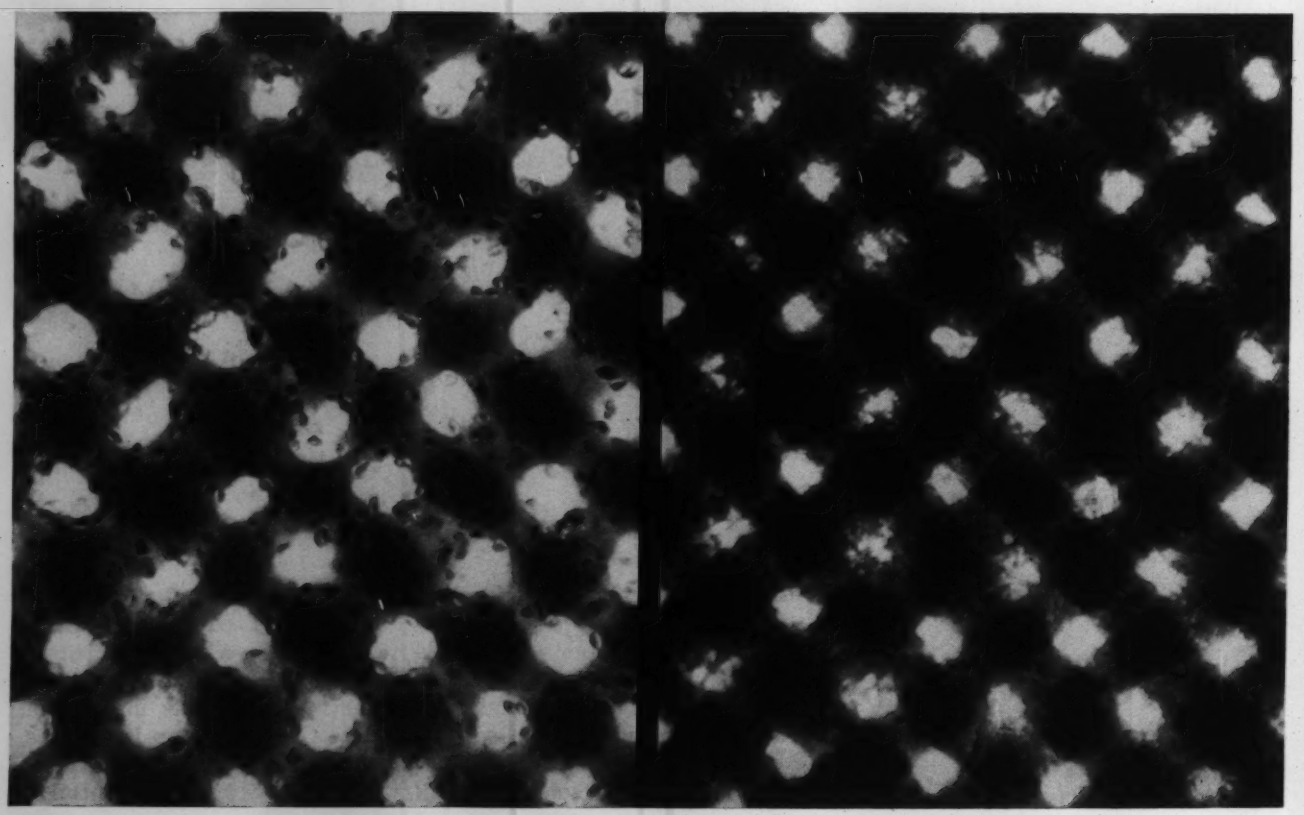
DISTRIBUTED NATIONALLY BY {American Hospital Supply Corporation and V. Mueller and Company

Now with Velva-Soft-G

hospital linens can fight infections



These companion photomicrographs show Velva-Soft-G's effective antibacterial control on a laundered sheet placed in a suitable medium seeded with Staphylococci. At left is the untreated sheet with dark "staph" colonies growing profusely. At right is the sheet treated with Velva-Soft-G. This picture clearly shows that Velva-Soft-G inhibited bacterial growth.

What Velva-Soft-G is:

It is a special cationic fabric softener with specific antibacterial chemicals to control a wide spectrum of germs, including the antibiotic-resistant strains of Staphylococcus aureus. Because of its cationic charge, Velva-Soft-G readily attaches itself to fabric when it's applied in the last cycle of the laundering operation.

Why it was developed:

Resistant strains of Staphylococcus aureus are held responsible for patient infection in many hospitals. Velva-Soft-G was developed to help hospitals' over-all environmental sepsis program—by controlling the spread of organisms on lint. The final formula evolved from variations tested on approximately three million pounds of hospital-washed linens.

How it controls germs:

Effective with the first application, Velva-Soft-G does two important things. (Regular laundering techniques do not do them.)

1. It gives fabric an antibacterial shield which remains effective even in prolonged storage. Velva-Soft-G effectively inhibits bacterial growth all the time linens are used. It continues to be effective in the crucial time when linens are being returned for re-washing and re-treatment.

2. It substantially reduces the incidence of air-borne infection through lint control. Bacteria literally ride on the lint particles from patient to patient. Lint is caused by fiber breakage. Velva-Soft-G's lubricity reduces fiber breakage and subsequent lint formation.

Velva-Soft-G does even more:

It softens all fabrics to increase patient comfort. It eliminates ammonia formation and odor in urine-soiled linens. Velva-Soft-G controls many strains of mildew-causing fungi which can be a problem when soiled, damp linens are stored prior to washing.

It is not toxic to patients:

Hospitals have evaluated Velva-Soft-G on linens used for many months without finding a single case of dermal sensitization due to Velva-Soft-G.

It is economical:

The cost is less than 3¢ per patient, per day. This should be considered in view of the objective of controlling infection on all hospital-treated linens. Velva-Soft-G can provide certain operating economies, too. It makes the laundry load easier to handle; reduces extraction and drying time; and eliminates static electricity for faster feed through the flatwork ironer. In addition, all treated fabrics will have a longer wear life because Velva-Soft-G's fiber lubricity reduces breakage.

Organism Counts on Treated and Untreated Linens*

*Upper figure represents beginning of operation, lower figure the end.

Treatment	Suds 1st	Suds 2nd	1st	2nd	3rd	4th	Sour Bath	Over-all Avg.
Total Organisms per Ml.*								
1. *Water Only* (no load)	1 1	1 1	0 0	1 2	4 4	1 2		1.5
2. *Regular Load* (bed jackets) Never treated with germicide	130 130	20 22	100 170	130 110	225 110	165 290	320 200	155.0
3. *Regular Load* (bed jackets) Treated with Velva-Soft-G before patient use	1 0	0 0	1 1	2 1	3 2	1 0	0 0	0.9

The over-all average indicates that Velva-Soft-G apparently reduced the high growth of organisms to the virtually germ-free level of the tap water.

For technical information on clinically-proven antibacterial treatment for hospital linens with Velva-Soft-G, please write: B. J. Augst, Manager, Industrial Soap Division, Armour and Company, 1355 West 31st Street, Chicago 9, Illinois.

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Formfitting grip allows complete freedom of surgical dexterity.

Professional Surgical Blades of the world's finest high tempered Swedish carbon steel insure extra sharpness and rigidity with highly sensitive balance. Sterilon Disposable Scalpel available with the following blades:

No. 10 — Stock No. S-10
No. 11 — Stock No. S-11
No. 20 — Stock No. S-20
Other sizes on request.

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DISPOSABLE SCALPEL

Sterile and Ready for Instant Use . . . anywhere

Here's the answer to the need for a practical, professional emergency scalpel.

Featherweight, perfectly balanced handle with blade affixed is guaranteed sterile and pyrogen-free. Sterilon Duo-Wrap packaging of each instrument permits complete asepsis upon entering sterile field. Requires no special previous handling because it's sterile until package is opened.

Sterilon's Disposable Scalpel is recommended for emergency surgery, first aid, suture removal, pathology, doctor's office surgical procedures and house calls.

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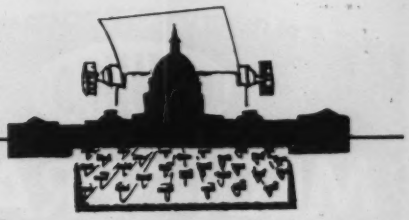


Kennedy Pledges Aid to Hospitals

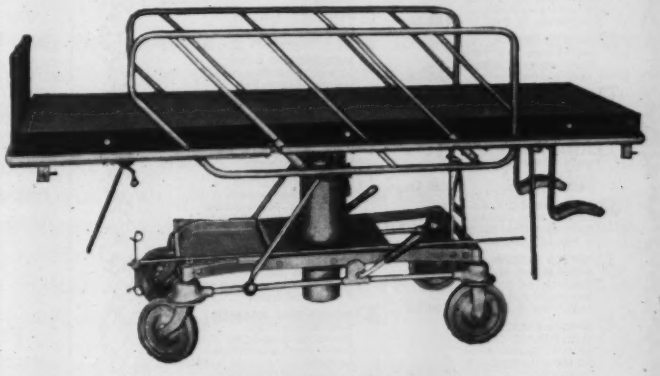
President Kennedy's first State-of-the-Union message, delivered just ten days after he took office, made it clear that he intends to keep the pledges in the health field which he gave during his campaign. In a speech which ranged the globe and covered key facets of foreign and domestic policy, he put strong emphasis on the lack of hospital beds, nursing homes and doctors. He also made his first public statement as President on health care for the aged, stating that a program to provide it through the social security approach "must be undertaken this year."

The new President's original speech to Congress also confirmed that the final Eisenhower budget, for the 1962 fiscal year, will be the basic blueprint for the first year of the Kennedy Administration. But he said some changes relating to his key programs will be proposed to Congress.

In the health field, the Eisenhower 1962 fiscal year budget figures are generally a little higher than his requests in the 1961 budget. However, in these cases, they are also generally lower than the amounts finally voted by Congress last year.

For the Hill-Burton program, the 1962 Eisenhower budget request is $151.2 million—an increase of $25 million over his previous year's request. Congress, however, voted an appropriation of $186.2 million for fiscal 1961 and, as of mid-January, Department of Health, Education, and Welfare statisticians estimated 1961 fiscal year expenditures would be about $155 million.

For the National Institutes of Health medical research program, the Eisenhower budget figure is $540 million, an increase of $140 million above the 1961 request. However, here again, Congress upped the appropriation, approving expenditures of $560 million for fiscal 1961. The former President made note of this in his final budget message. He said that while the 1962 request "is $20 million less than the 1961 appropriation, it actually represents a substantial program increase for medical research and training. The reduction results from the elimination in 1962 of



Patients and Staff agree . . . it's

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HYDRAULIC STRETCHER

for day-after-day-after-day satisfaction

Another dramatic demonstration that "Through the Years —RELIANCE Quality tells!"

The versatility of this all-round Stretcher pays off everywhere: recovery room, emergency room, shock therapy treatment. A boon to the HOSPITAL because it saves valuable nurse-time to a remarkable degree, and assures the patient of maximum comfort and ease.

Trendelenberg position in *7 seconds*. Other exceptional labor-saving features!

See RELIANCE Model 41-AA Hydraulic Stretcher at your dealer or write for brochure.

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nonrecurring projects and from the transfer of programs to other parts of the Public Health Service which were included in the total for the National Institutes of Health for 1961."

For health research facilities, the Eisenhower budget figure is $30 million, $5 million more than the 1961 request and identical to the amount appropriated by Congress last year.

Other Eisenhower budget requests include $73.1 million for the "Medicare" program for health care in civilian facilities of dependents of armed services personnel. The 1961 budget figure was $71.3 million. The new Veterans Administration figure is $5.3 billion, about $69 million more than estimated 1961 expenditures. Of the 1962 total, $1.025 billion is earmarked for hospitals and medical care with an additional $66 million for hospital construction.

The final Eisenhower budget also proposed certain new legislation. In the hospital field, the former President asked for new legislation "to encourage coordinated community and regional planning of hospital facilities, to augment research on design and operation of hospitals, and to permit use of grants for high priority modernization projects." Since President Kennedy is known to favor hospitals renovation and modernization, the prospects for legislation in this area are promising.

Broader Aged Health Care Urged by Eisenhower

Former President Eisenhower is on record as favoring a broader program of health care for the aged. In his final budget message, he referred to the federal-state program enacted by Congress last year (Kerr-Mills Bill—Oklahoma's Democratic Senator Robert Kerr and Arkansas' Democratic Representative Wilbur Mills). He said a federal-state program is "sound national policy," but, he added, "under the program approved by the Congress many of the aged will still not be able to obtain needed protection against catastrophic hospital and medical expenses even though under ordinary circumstances they are able to pay their normal medical bills."

Dr. Terry Named New Surgeon General

President Kennedy's choice for Surgeon General, succeeding Leroy E. Burney, M.D., is Luther Leonidas Terry, M.D., a Public Health Service career medical officer since 1942. In an informal meeting with Washington news correspondents just prior to Inauguration Day, Dr. Terry reported some of his personal opinions on health matters. When questioned, for example, on his views on social security financing of aged health care, he said: "Frankly, my personal leanings are toward this method of support." He was asked about speculation that the National Institutes of Health might become an autonomous group. His reply was that he had never even heard such reports. He was also questioned on his opinion on the current 15 per cent ceiling on indirect costs of NIH research projects. He answered he is personally convinced the limitation "does not pay indirect costs" and that he is in accord with raising it.

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1960 HEW Publication Reports Trends in Health Care, Manpower and Facilities

In 1959, there were approximately 133 physicians per 100,000 population; a total of $990 million was spent on hospital construction, and hospital use—patient days per capita—had increased approximately 50 per cent since 1931.

These facts are part of a large graphic compilation of data found in the 1960 edition of "Health, Education, and Welfare Trends." Recently published by the U.S. Department of Health, Education, and Welfare, this edition is the first to be made available to the general public. It represents a pioneer effort to acquaint the public with statistical data as an aid to understanding past developments and analyzing current and emerging problems in the fields of health, education and welfare.

Arthur S. Flemming, former secretary of Health, Education, and Welfare, states in the preface that "although the well-being of the people has been measurably improved, some old problems remain and new ones have emerged. The task for the 1960s and beyond is not only to insure that the training of manpower, construction of facilities and support of research keep pace with the growing needs of an expanding population, but also to raise the levels of living of the population even further."

The information tabulated on most subjects includes at least preliminary data for 1959, although some subjects are carried only through 1958.

The publication gives broad coverage to the many subjects within each of the three fields studied. In the health field, the subject matter areas are: Measures of Illness and Medical Care, Incidence of Disease, Health Manpower, Private Expenditures for Medical Care and Voluntary Health Insurance, Hospital Facilities and Health Facilities.

The following are summaries of a few specific findings:

● *Health Manpower: Medical Graduates and Physicians*—The number of graduates from medical schools totaled 6895 in 1959, or approximately the same number that have been graduated during each of the past several years, except for an upsurge in 1944 when the figure almost doubled. Accordingly, the number of physicians has remained about the same since World War II. In 1959, there were 235,000 physicians in the United States compared with 201,277 in 1949. There are, according to the latest figures, 133 physicians per 100,000 population.

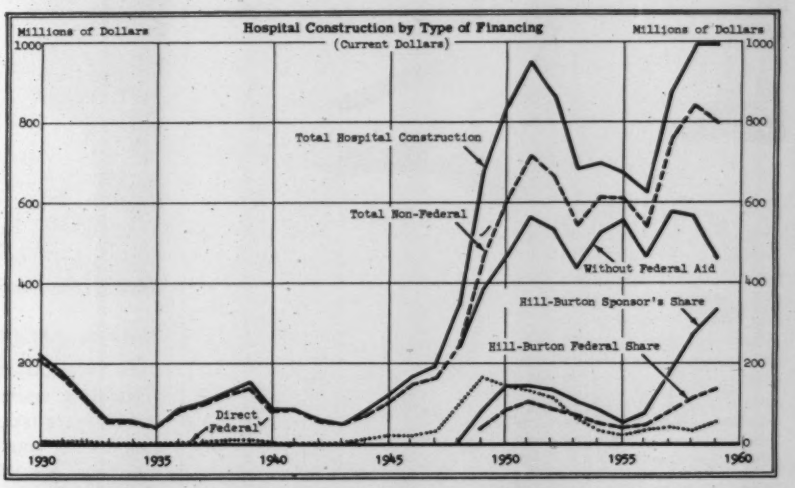
● *Private Expenditures for Medical Care and Voluntary Health Insurance*—In 1958, private expenditures for medical and hospital care, drugs and appliances and health insurance totaled $16.4 billion, or five per cent of personal income. Per capita expenditures were nearly $96 annually, distributed as follows: $30 for hospital services, $25 for physicians, $25 for medicines and appliances, $10 for dentists' services and $6 for all other medical expenditures. This total has grown from $7.6 billion in 1948.

● *Hospital Use: Admissions and Patient Days*—The use of general and special hospitals has increased markedly since 1931. Total days in hospital per capita have risen almost 50 per cent. Although the rate of admissions to hospitals has increased—a slight decrease occurred in 1959 compared with 1958—the average length of stay per admission has declined.

● *Health Facilities: Hospital Beds*—There were approximately 1.6 million hospital beds in the United States in 1958, a slight increase over 1957. The steady growth in the number of beds in general and special hospitals since 1949 has kept pace with population growth.

● *Health Facilities: Hospital Construction*—Of total hospital construction approximating $1 billion in 1959, 80 per cent was financed by nonfederal sources. The remaining 20 per cent consisted of direct federal construction, such as veterans and Indian hospitals, and of funds made available under the federal hospital and medical facilities construction program (Hill-Burton). After the low levels of the depression and World War II years, hospital construction increased rapidly, reaching $947 million in 1951, and almost $1 billion in 1959. After allowance has been made for increases in construction costs, the postwar construction is approximately three times the 1930-46 average.

Statistical data used in preparation of "Health, Education, and Welfare Trends" was gathered from within the U.S. Department of Health, Education, and Welfare, from other U.S. government agencies and from private organizations including the American Hospital Association. ■



Representative of more than 90 graphs included in the 1960 edition of "Health, Education, and Welfare Trends," this graph plots the various means of financing hospital construction from 1930 to 1959. Of the $1 billion spent on hospital construction in 1959, for example, 80 per cent was financed from nonfederal sources (i.e., without federal aid, Hill-Burton sponsor's share) and 20 per cent from direct federal aid (i.e., Hill-Burton federal share).

Michigan Plans Ask 'Deficit' Rate Boost

Michigan Blue Cross and Blue Shield last month requested a composite rate increase of 18.7 per cent. The need for the increase is attributed to higher hospital costs and greater use of needed services by members.

The requests—22 per cent for Blue Cross and 13.5 per cent for Blue Shield—are calculated as the minimum needed to restore the plans to a sound financial position, and to retain this position for at least two years, officials said. The increase has been asked for all coverages except the special nongroup over-65 contract. If granted, they would cost the plan's 3,675,000 subscribers approximately $42.7 million a year.

State approval is necessary, and Frank Blackford, state insurance commissioner indicated that the first public hearings would be called probably in early February in Detroit. The Plans requested an April 1 effective date.

William S. McNary, executive vice president of Blue Cross, and L. G. Goodrich, executive vice president of Blue Shield, said that both plans operated in the red during 1960, and that output was exceeding income at a greatly accelerated rate so far in 1961. The last Blue Cross rate increase went into effect more than two years ago. Blue Shield's May 1960 petition for an increase was granted, but the requested 19.5 per cent increase was cut to 11.5 per cent.

The officials declared that the rate increase requests stem from the simple fact that the costs of providing medical care services by Blue Shield are rising at a rate of at least 7 per cent annually and the hospital care costs paid by Blue Cross are increasing at the rate of more than 9 per cent per year. Mr. Goodrich said that because the May 1960 request was cut, "we are still faced with a deficit that produced an actual minus-reserve at the end of 1960 and that this minus-reserve will have risen to nearly $2 million by April of this year."

Mr. McNary stated that the need for Blue Cross rate adjustment reflected two key factors: (1) Costs to hospitals of providing hospital services have been rising steadily for over a decade, and (2) the number of admissions for needed hospital care has also been rising steadily.

Both officials said that the increase requests were based on a careful projection of patterns of advances in hospital and medical care costs, and anything lower would be "dangerously low".

Several Blue Cross benefit liberalizations which have been requested by many members and which add very little to the total cost of coverage have also been proposed.

Insurance Company Asks Hospital Records Inspection

An insurance company in Oklahoma City has requested a federal court order directing Oklahoma's hospitals to open medical records to inspection.

Pyramid Life Insurance Co. made the request after declaring it necessary to halt what it called fraudulent hospitalization insurance claims.

"An opinion establishing the

(Continued on page 120)

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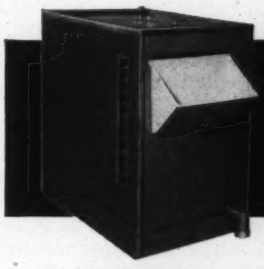

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right of inspection," stated the brief filed with the federal court, "will enable insurers throughout the country to obtain information which they require for the prompt and fair settlement of their hospital and medical claims of insureds without the tedious expenditure of time and money involved in court litigation."

The insurance company has been involved in a lawsuit for the past year with a municipal hospital in Cushing, Okla. Pyramid claims 81 of 161 claims filed by patients during recent years were "fraudulent" and is seeking to recover $6774 from the hospital. The company's charges are based on its investigations which indicate the hospital prepared medical reports on patients filing claims which did not correspond with the hospital's medical records.

The practice, the company asserted, is in part responsible for the high cost of hospitalization insurance in Oklahoma. ■

Quebec Joins Canadian Hospital Insurance Plan

An agreement which will extend provisions of the Hospital Insurance and Diagnostic Services Act to residents of the Canadian province of Quebec, went into effect Jan. 1, 1961.

The program which the Hon. J. Waldo Monteith, Minister of National Health and Welfare, called "the most important single advance achieved in the subsequent development of our nationwide hospital system," will cover approximately five million people. Following the pattern of other provincial programs, it will include such inpatient hospital services as standard ward accommodations, necessary nursing services, use of operating room and anesthetic facilities, radiotherapy and physiotherapy, drugs and surgical supplies and diagnostic procedures including necessary interpretations when required.

Services for outpatients are not presently included, but an extension into this area is envisaged in provincial legislation.

The Quebec program does not call for the levying of a premium or for the imposition of an authorized charge—a coinsurance or deterrent charge. Charges may be made for extra services involved in a semiprivate or private room accommodation for example, and for the services of physicians and surgeons.

The cost of the program will be shared by the federal and provincial governments. The federal contribution on behalf of hospital insurance amounts to approximately 50 per cent of national costs.

The signing of the agreement with Quebec concludes a process of implementing the hospital insurance act which began in March 1958 when an agreement was signed with Ontario. In July 1958, operations began in British Columbia, Alberta, Saskatchewan, Manitoba and Newfoundland. Nova Scotia's plan got underway in January 1959, and New Brunswick followed in July 1959. Prince Edward Island, the Northwest Territories and the Yukon followed in late 1959 and 1960. ■

Blue Cross-Blue Shield Plans Describe Financial Situations

Associated Hospital Service of Philadelphia (Blue Cross) ended 1960 with its largest reserve fund in three years—nearly $7.5 million.

E. A. van Steenwyk, Blue Cross executive vice president, said that despite record payments to hospitals, the Philadelphia Plan is in "excellent" financial shape. He attributed the improved financial picture to two factors: the last Blue Cross general rate increase a year and a half ago, and the settlement of its contract disputes with member hospitals.

Mr. Van Steenwyk reported that Blue Cross has paid hospitals over $60 million during 1960, and that payments to hospitals for patient care were over $5.4 million in November alone. Payments to hospitals, he said, are now running at an annual rate of $5 million greater than last year, but despite the fact that hospital costs and the cost of care have been rising, "the financial results in this past year are better than we had anticipated . . ."

ALBANY PLANS REQUESTS INCREASE

Blue Cross and Blue Shield in Albany, N.Y., have asked the State Insurance Department to approve rate increases which would go into effect April 1. The increases would average 26.08 per cent for Blue Cross and 39.30 per cent for Blue Shield.

The proposed Blue Cross increase would not apply to the experience-rated state employees' plan, to the newly introduced over-65 plan, to

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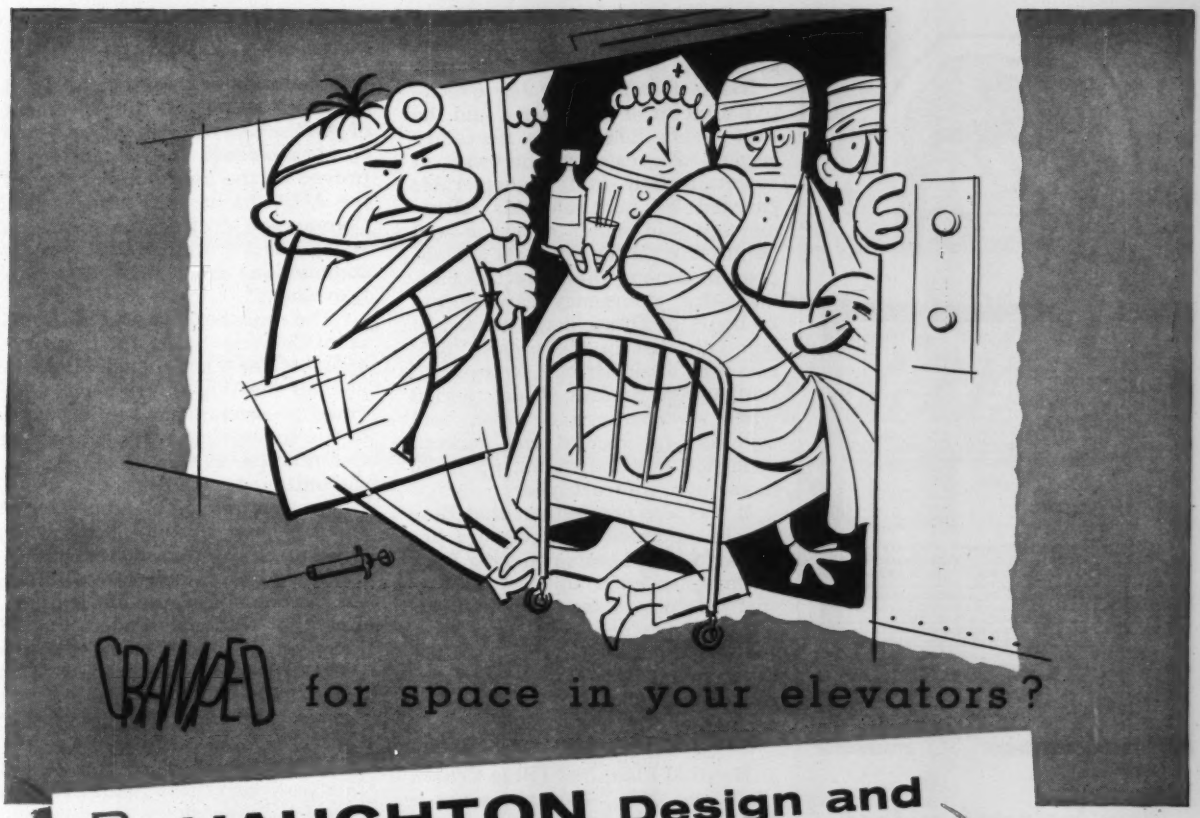

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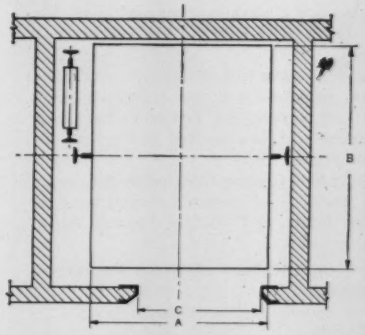

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the $50 deductible plan, or to the master group plans of some companies.

Ralph Hammersley Jr., executive director of both plans, said the Blue Cross increase is necessary because of greater public usage of hospitalization and higher rates charged by hospitals. Mr. Hammersley said wider coverage will be provided if the requests are approved. Among these are full payment for emergency care within 24 hours of an accident, instead of being limited to the present $15; coverage of sick infants from birth without the present 60-day period when no coverage is given, and coverage for mental and nervous condition hospitalization, up to 30 days in a contract year.

It was also pointed out that Blue Shield increases are necessary because of added costs resulting from a "much-needed upward adjustment of doctors' fees—the first real adjustment since 1946," and from the introduction on Dec. 1, 1959, of payment for diagnostic x-ray in doctors' offices.

UTICA PLANS REQUESTS RATE HIKE

Hospital Plan, Inc. (Blue Cross), of Utica, N.Y., has requested a 27.5 per cent increase to be effective April 1. Nearly 250,000 subscribers would be affected.

Harold N. Howell, managing director of Blue Cross-Blue Shield plans, said an increase in the number of hospital admissions coupled with a raise in hospital costs brought on the rate increase request. The last adjustment granted to the Plan involved a 31.6 per cent increase in July 1959.

N. J. PLANS AWAIT DECISIONS

New legislation governing the Blue Cross and Blue Shield hospitalization and medical-surgical plans in New Jersey is expected to be offered early in March.

A special legislative committee headed by Sen. Wayne Dumont (R-Warren) has been studying costs of the Plans and holding public hearings for several months. The committee met several times in January with its counsel, Martin Kesselhaut and Victor De Fillippo, to review testimony.

An application for a 23.5 per cent rate increase by Blue Shield is pending before State Banking and Insurance Commissioner Charles R. Howell. It is the Plans' first request for a general raise in rates on an existing contract since its organization in 1942. If approved, the increase would be effective May 1. ■

Commission For Bettering Patient Care Dissolved

Dissolution of the National Joint Commission for the Improvement of the Care of the Patient, as voted by its members, was recently approved by the Board of Trustees of the AHA. At its final meeting, the Commission drafted the following statement for transmittal to state commissions on patient care improvement:

"The members of the National Joint Commission for the Improvement of the Care of the Patient, at their meeting November 6, 1959 voted to recommend to the boards of the sponsoring agencies that the Commission, as now organized, be discontinued.

The Commission has represented the American Hospital Association, the American Medical Association, the American Nurses' Association, the National League for Nursing, and the National Federation of Licensed Practical Nurses. When the Commission was organized in 1948 there was need for a medium through which to develop better interassociation understanding. The Commission has accomplished this in a significant manner. This has been a contribution which will have a lasting benefit.

As a result of the understanding engendered, better liaison has been developed between several of the associations. There is reason to believe that this liaison will grow and become stronger.

From the very beginning it was the hope of the members of the Commission that the working philosophy of the Commission would be picked up in the states and particularly in individual hospitals. This has proved to be the case.

The commissioners believe that the problems now are of the kind that can best be and perhaps should be handled within the hospitals or at the state level. The pamphlet, 'Mobilizing Your Personnel Resources for Better Patient Care,' outlines steps for the development of sound interrelationships within a hospital." ■

Iowa State Offers Short Engineering Course

The first annual Short Course in Hospital Engineering will be offered at Iowa State University, Ames, March 6 to April 29, 1961.

Enrollment, which will be limited to 40, is open to administrative staff, engineers and other personnel in hospitals who are concerned with engineering aspects of the

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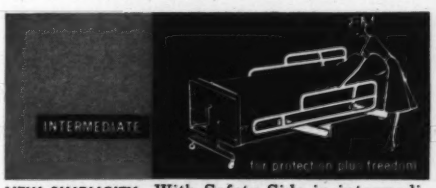

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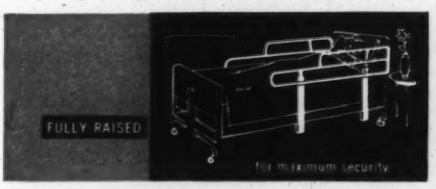

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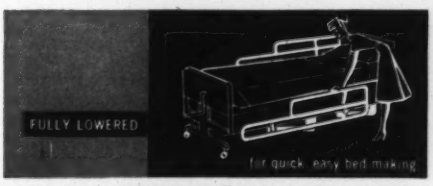

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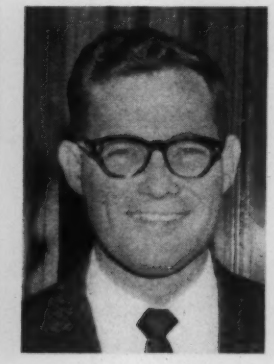

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hospital operation. Persons professionally engaged in hospital planning including architects, consulting engineers and members of planning agencies may also attend.

The course is sponsored by the American Hospital Association in cooperation with Iowa State University. Registration blanks have been forwarded to most hospitals; further information may be obtained from the American Hospital Association, 840 North Lake Shore Drive, Chicago 11, Ill. ■

JCAH Elects Officers; Dr. Nelson New Chairman

The Commissioners of the Joint Commission on Accreditation of Hospitals at their meeting on Dec. 10, 1960, elected the following officers: Russell A. Nelson, M.D., Johns Hopkins Hospital, Baltimore, Md., chairman; James Z. Appel, M.D., Lancaster, Pa., vice chairman, and Stuart K. Hummel, Milwaukee, Wis., treasurer.

John I. Brewer, M.D., Chicago, is the retiring chairman of the Commission. ■

Connecticut Blue Cross Granted AHA Approval

Connecticut Blue Cross, Inc., has been granted official approval by the American Hospital Association. The action took place at the Nov. 18, 1960, meeting of the Board of Trustees of the AHA. Approval as a Type IV institutional member carries with it national approval of the Plan's programs and policies.

The Connecticut Blue Cross Plan has also announced that as of Feb. 1, 1961, all maternity benefits were increased to $125 per case, except for a few remaining standard plan program contracts. The broadened policy is a result of a rate increase of 13.4 per cent recently authorized by the state insurance department. ■

Groups Elect Officers

Central New York Regional Council, Inc.: President, James H. Abbott, administrator, University Hospital of the Good Shepherd, Syracuse; vice president, Milton C. Jones, director, St. Luke's Memorial Hospital Center, Utica; treasurer, Gerald F. Wagner, assistant administrator, Charles S. Wilson Memorial Hospital, Johnson City.

District of Columbia Hospital Association: President, Sister Eleanor, R.N., administrator, Providence Hospital; president-elect, Charles E. Burbridge, Ph.D., superintendent, Freedmen's Hospital; treasurer, John A. Oley, administrator, Columbia Hospital for Women and Lying-In Asylum; secretary, William M. Bucher, executive director, Hospital Council of the National Capital Area, Inc.

Idaho Hospital Association: President, Grant C. Burgon, administrator, Idaho Falls Hospital of the Church of Jesus Christ of Latter-Day Saints, Idaho Falls; president-elect, William C. Hansen, administrator, Mary Secor Hospital, Emmet; secretary-treasurer, Sister Alma Eugene, controller, St. Alphonsus Hospital, Boise; executive secretary, Jon A. Ogden, Boise.

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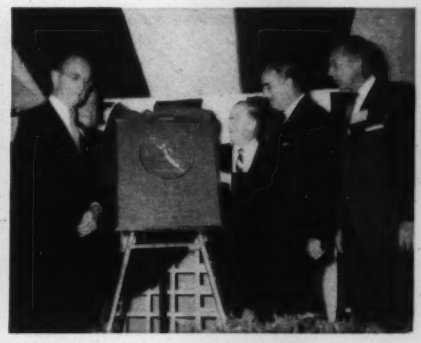
From the address by Irvine H. Page, M.D., Director of Research, Cleveland Clinic Foundation, at ceremonies of October 6, 1960 held in dedication of the Pfizer Medical Research Laboratories



The 400 scientists and supporting technical and administrative staff in the microbiological, macrobiological, chemical and biochemical research units of the Groton laboratories are part of the world-wide Pfizer research team. This international research project numbers 1,000 men and women who, through organized knowledge, help to create new and better drugs ...all in quest of freedom from disease.

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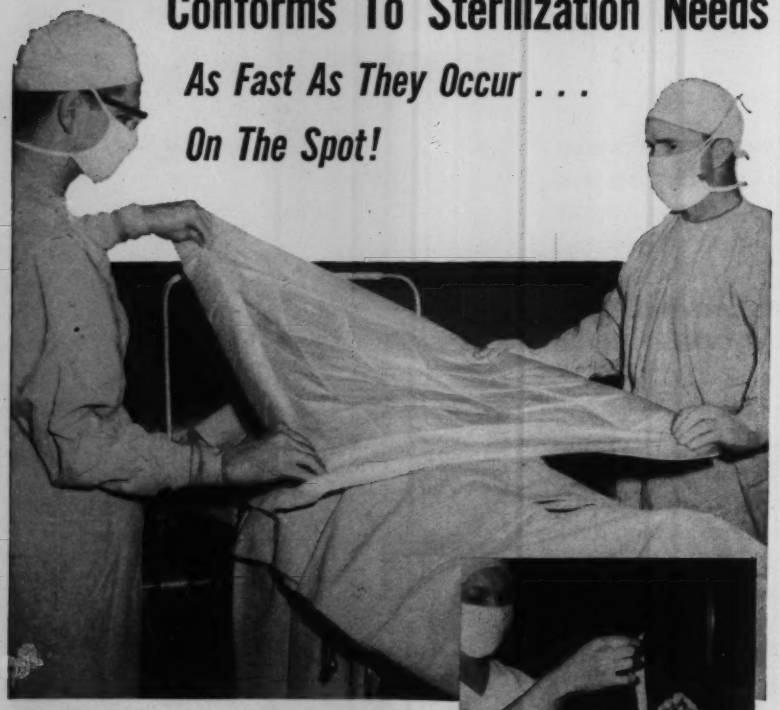

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dent, Lloyd N. Hermansen, administrator, Dodge County Community Hospital, Fremont; president-elect, John Estabrook, administrator, Nebraska Methodist Hospital, Omaha; vice president, Donald W. Duncan, assistant administrator, St. Elizabeth Hospital, Lincoln; secretary, Paul Piper, administrator, Boone County Community Hospital, Albion; treasurer, Henry Reimer, administrator, Mennonite Deaconess Hospital, Beatrice.

Accreditation problems

(Continued from page 28)

good medical practice. The committee should be guided by the Standards of the Joint Blood Council, Inc., and the American Association of Blood Banks and other authorities. The hospital pathologist should be a member of this review committee and the committee should have representation from all major clinical services.

"3—That there be adequate procedures for identification and compatibility testing of blood in the hospital under the immediate supervision of a qualified physician, and these procedures shall be made a matter of record with the transfusion committee and the medical staff.

"4—That this committee review transfusion reactions occurring in the hospital, making a complete investigation concerning possible causes of these reactions, and based on these investigations make recommendations to the medical staff, if necessary, for improvement of blood transfusion practice."

A special point is made for investigation of all "single" transfusions in terms of their actual necessity.

Hospital association meetings

(Continued from page 6)

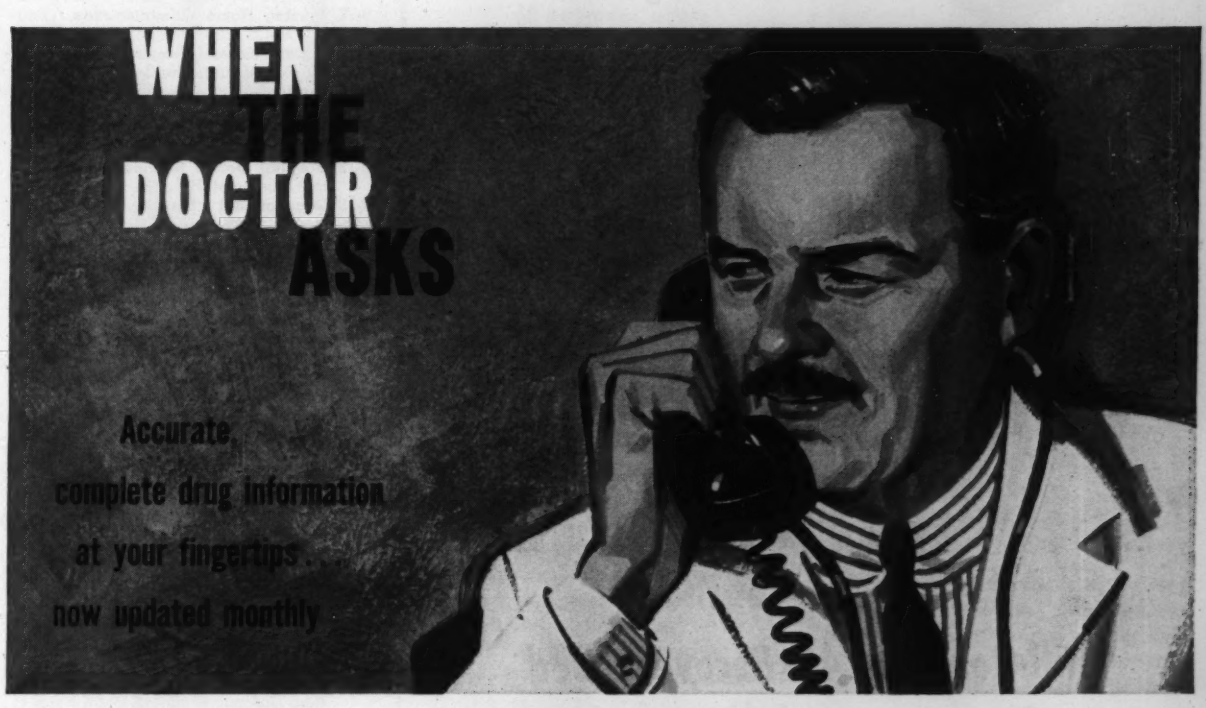
tion, San Antonio, Tex. (Brooke Army Medical Center, Fort Sam Houston)

8-10 **Hospital Organization,** New York City (Sheraton-Atlantic Hotel)

8-10 ***Machine Accounting and Data Processing,*** Chicago (AHA Headquarters)

8-10 ***National Red Cross Convention,*** Cincinnati

(Continued on page 128)



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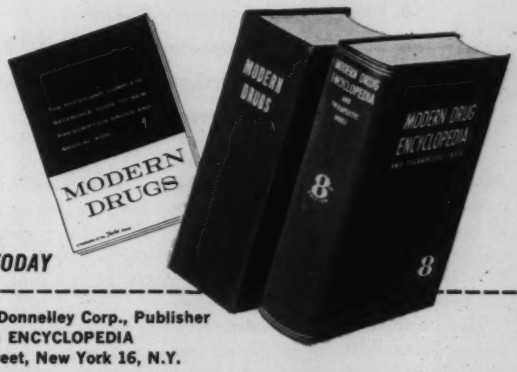

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8-12 *American College of Physicians,* Bal Harbour, Miami Beach (Americana Hotel)
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9-12 **Nursing Home Administration,** Omaha, Nebr. (Sheraton-Fontenelle Hotel)
10-12 Upper Midwest Hospital Conference, St. Paul (Auditorium)
11 Massachusetts Hospital Assembly, Boston (Statler Hotel)
14-17 Texas Hospital Association, Dallas (Memorial Auditorium)
15-18 **Hospital Dental Service (Basic),** Boston (Somerset Hotel)
15-18 **Occupational Therapists,** Washington, D.C. (Willard Hotel)
17-19 Hospital Association of New York State, Atlantic City, N.J. (Convention Hall)
17-19 Middle Atlantic Hospital Assembly, Atlantic City, N.J. (Convention Hall)
17-19 New Mexico Hospital Association, Albuquerque (Western Skies Hotel)
22-25 **Evening and Night Nursing Service,** Detroit (Pick-Fort Shelby Hotel)
22-26 **Shared Dietitian and Dietary Consultant,** Chicago (AHA Headquarters)
23-24 **Credits and Collections,** Atlanta (Henry Grady Hotel)
26-27 Tennessee Hospital Association, Gatlinburg (Riverside Hotel)
29-31 Arkansas Hospital Association, Hot Springs (Arlington Hotel)

JUNE

1-2 New Hampshire Hospital Association, Newcastle (Wentworth-by-the-Sea)
2-7 *American Physical Therapy Association,* Chicago (Palmer House Hotel)
5-7 **Hospital Purchasing (Advanced),** Chicago (AHA Headquarters)
5-8 Maritime Hospital Association, Halifax, N.S. (Nova Scotian Hotel)
5-9 International Hospital Federation, Venice, Italy
6-7 Maine Hospital Association
6-8 **Patterns and Principles for Auxiliary Leaders,** Washington, D.C. (Willard Hotel)
11-16 American Society of Medical Technologists, Seattle (Olympic Hotel)
12-15 **Nursing Service Supervision,** Chicago (AHA Headquarters)
12-15 Catholic Hospital Association, Detroit (Cobo Hall)
14 Connecticut Hospital Association, Berlin
18-20 Michigan Hospital Association, Grand Rapids (Hotel Pantlind)
19-21 **Administrators' Secretaries,** Chicago (AHA Headquarters)
19-23 **Hospital Pharmacy (General),** Albany, N.Y. (Sienna College)
21-23 North Carolina Hospital Association, Asheville (Grove Park Inn)
24-29 *International Convention of X-ray Technicians,* Montreal (Queen Elizabeth Hotel)
26-28 **Executive Development of Departmental Directors,** Chicago (AHA Headquarters)
26-28 Comité des Hopitaux du Québec, Montreal (Show Mart)
26-29 **Supervision,** Little Rock (University of Arkansas Medical Center)
26-30 *American Medical Association,* New York City (Coliseum)

JULY

16-21 *19th Annual Institute of the American Association of Hospital Accountants,* Indiana University, Bloomington
31-Aug. 4 **Hospital Purchasing (Advanced),** Kansas City (Bellerive Hotel)

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See opposite column for one specific Airkem benefit ▶

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AIRKEM
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How changing patterns of payment affect hospital planning

(Continued from page 62)

ward or clinic patient would not be charged a professional fee if he does not have Blue Shield or other insurance. The remedy to this situation is simple. Charges should be made for professional services to *all* ward and clinic patients and should be written off when patients are unable to pay.

The role of American hospitals is inexorably tied to the future of medical science and, especially, to the future of our economy and social system, as well as that of the whole world. It is time that we sat down and took stock of the whole situation, not just among ourselves but together with the public if we want to get our future straight. We must learn to look at hospitals as just a small though vitally important part of all the medical, economic, social and political circumstances if we are to make any sense for the future.

Only as hospitals become involved in planning for both immediate and long-range objectives will they know *where they are going* and how they are going to get there. ■

Planning the patient space

(Continued from page 53)

The person working in one of the rooms holds the hose in the right hand and the pan in the left hand—the best position for right-handed persons. However, in the other room, the hose must be held in the left hand and the pan in the right—an awkward position for right-handed persons. This difficulty can be avoided if the hose connection is placed at the right of each toilet.

Wall Protector. The wall at the head of a bed gets severe abuse unless it is protected. Some type of bumper should be installed at floor level to keep the bed and any protruding equipment away from the wall.

(Continued on page 130)

Airkem Helps Fight Cross Infection!

Infections committees in many leading hospitals are adopting Airkem techniques in their continuing fight against "staph" and other infections. They find the Airkem method helps effectively.

HOW?

Airkem attacks the essence of the problem —by halting, minimizing or preventing the spread of bacteria, fungi, protozoa. Cleaning and disinfecting are combined in every daily sanitation maintenance task, yet without adding to work-load of maintenance personnel. At point of contamination, suspected or unsuspected, Airkem methods set up a routine barrier. Each cleaning task becomes a microorganism-killing treatment – for walls, floors, rest rooms, laboratories, bedpans, urinals, surgical waste receptacles, diaper cans, garbage cans, everything. Cross-infection cannot "cross" without a crossing-place!

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Door Hinge. The traditional door hinge exposes the edge of the door to possible banging by wheeled equipment and beds. The opening is also reduced in width by nearly the thickness of the door. An offset hinge throws the edge of the door out of the opening and thus protects it. It also makes available the entire opening between the door stops.

Beds Per Utility Service. Rooms with the heads of the beds on the same wall make it possible to provide services to four beds from one source (lights, call system, radio, telephone, oxygen, etc.). Two sources of supply in each room must be provided if the heads of the beds are placed on opposite walls.

Double Leaf Door. It has been felt that a double leaf door reduces the effort needed to move it, reduces its length of protrusion into the room and yet allows full width for the passage of beds by opening both leaves. Still, some hospital planners do not favor this type of door because: (1) it increases hardware cost; (2) it increases noise when both sections begin to rattle, and (3) it results in greater damage to doors by trying to pass wheel chairs and other equipment through the opening when the smaller section of the door remains closed.

Toilets. Toilet room planning should include a discussion of wall-hung versus floor-mounted toilet fixtures. The wall-hung fixture results in a possibility for better cleaning around the toilet but higher cost and increased repairs if the fixture is improperly installed.

There is always danger in being too specific in a dynamic planning world that is constantly subject to changing concepts. On the other hand, there is also danger in overlooking the important units that either increase or decrease efficiency of care and patient comfort. It is with a full realization of both dangers that the author has written this paper, in the hope that such small items as the directional swing of a door may receive more study than has often been the case.

The administrator and the hospital consultant should be sure that their understanding of patient care is brought to bear on hospital planning. They should remember that although air-conditioning is important to patient comfort, so is the location of the lavatory. ■

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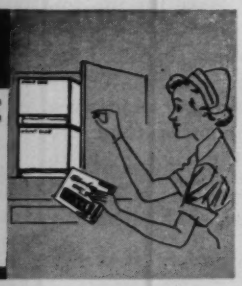

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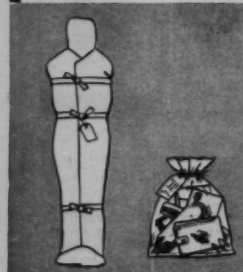

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ASSISTANT DIRECTOR: Gynecologic and Obstetric Nursing, approximately 200 beds including 66 bassinets. Master's degree in Nursing Service Administration. Obstetrical nursing experience desirable. Salary commensurate with experience and qualifications. Progressive personnel policies. Write to Director, School of Nursing and Nursing Service, The Johns Hopkins Hospital, Baltimore 5, Maryland.

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NURSE ANESTHETISTS: Two (2) required, salary to $700 per month, depending on experience. New fifty bed hospital, liberal personnel policy. Apply Administrator, Dearborn County Hospital, 600 Wilson Creek Rd., Lawrenceburg, Indiana, or phone collect, 1010.

COMBINATION X-RAY AND LABORATORY TECHNOLOGIST: To work with present technician. Salary open and commensurate with ability and experience. 40 bed hospital. Write: Mr. John B. Kohl, Administrator, Grundy County Memorial Hospital, Grundy Center, Iowa.

ASSISTANT DIRECTOR: Medical-Surgical Nursing, approximately 400 beds including metabolism unit and general recovery room. Master's degree in Nursing Service Administration and/or Medical-Surgical Nursing. Salary commensurate with experience and qualifications. Progressive personnel policies. Write to Director, School of Nursing and Nursing Service, The Johns Hopkins Hospital, Baltimore 5, Maryland.

DIETITIAN: needed for 93 bed JCHA approved general hospital located on South Atlantic coast. Prefer ADA member with hospital experience. Good personnel policies. Salary open. Send resume, including references, experience, date available, and salary desired in first letter. Apply Miss Ruth M. Puehler, Administrator, Georgetown County Memorial Hospital, Georgetown, South Carolina.

MALE R.N. with psychiatric experience. Beginning salary up to $6,540 per annum in accordance with training and experience. Periodic salary increase on merit. Retirement, social security, group disability, vacations, sick leave, and other fringe benefits. R. R. Cameron, M.D., Superintendent, Security Mental Health Hospital, Box B, Anamosa, Iowa.

ADMINISTRATOR for Chronic Hospital, 137 beds. Hospital planning expansion programme. Excellent opportunity for experienced and willing individual. All applications must be in writing and will be treated in confidence. Address: Mr. Nat Cohen, c/o Jewish Hospital of Hope, 7745 Sherbrooke Street, E., Montreal 5, P.Q., Canada.

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NURSE ANESTHETIST, REGISTERED: to join another to complete coverage. Write Administrator, Rice County District one Hospital, Faribault, Minnesota.

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DIRECTOR OF NURSING REQUIRED: The Royal Alexandra Hospital is at present a 729 bed hospital which is expanding to 1300 beds. Salary is open depending on qualifications and experience. If interested please contact Dr. D. R. Easton, Executive Director, Royal Alexandra Hospital, Edmonton, Alberta, Canada.

OBSTETRICAL SUPERVISOR: for 600 bed modern general hospital completing large addition. Full approved accredited school of nursing. Excellent salary, generous benefit program, 4 weeks vacation, Apply personnel Director-Christ Hospital, Cincinnati, Ohio.

ANESTHETIST: for 28 bed hospital, Salary to $700.00. Good working conditions. New well equipped hospital. West Coast Location with mild climate. Call collect, Administrator, Western Lane hospital, 112 or 297J. Florence, Oregon.

NURSING DIRECTOR, SUPERVISORS, HEAD NURSES: New 50 bed hospital. Low living cost resort area, to open summer 1961. Write administrator, Community Hospital, Toms River, New Jersey.

DIRECTOR for private clinical laboratory in Eastern Massachusetts. Background in clinical Chemistry, medical administration and accounting desired. Advanced degree preferred. Beginning salary $8,000 to $11,000. Reply in confidence to MASSACHUSETTS MEDICAL BUREAU, 18 Tremont Street, Boston 8.

OPERATING ROOM SUPERVISOR: New 72 bed acute hospital; 45 miles from twin cities; Write Administrator, Rice County District one Hospital, Faribault, Minnesota.

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(Continued on page 132)

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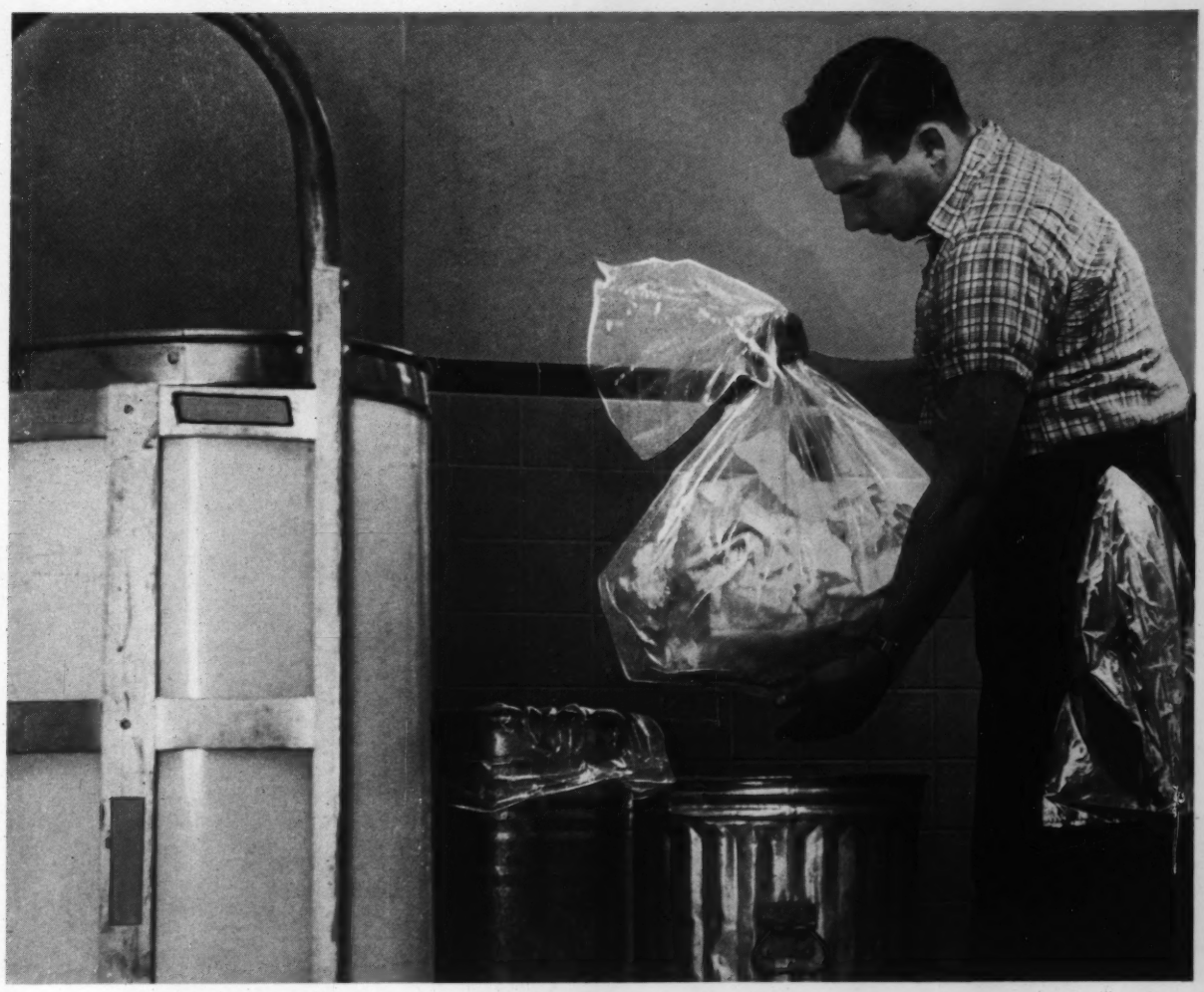

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